H.R. 864—A BILL TO IMPROVE VETERANS' BENEFITS FOR FORMER PRISONERS OF WAR

HEARING

BEFORE THE

SUBCOMMITTEE ON
COMPENSATION, PENSION, AND INSURANCE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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H.R. 864—A BILL TO IMPROVE VETERANS' BENEFITS FOR FORMER PRISONERS OF WAR

WEDNESDAY, JUNE 19, 1985

House of Representatives,
Subcommittee on Compensation,
Pension and Insurance,
Committee on Veterans' Affairs,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:05 a.m., in Room 334, Cannon House Office Building, Hon. Douglas Applegate (chairman of the subcommittee) presiding.

Present: Representatives Applegate, Montgomery, Mica, Dowdy, Evans, Hammerschmidt, and Molinari.

OPENING STATEMENT OF CHAIRMAN APPLEGATE

Mr. Applegate. Good morning. The hearing is about ready to begin.

I just want to say good morning to all of you, and I certainly want to welcome this great group of veterans to the Capital of the United States, to see all these great people in this audience. It isn't very often that we get this large a group for a hearing, so you are very welcome.

Unfortunately, some of you are standing—not that you're not used to standing many times—but I'm sorry we could not secure a larger room for you so that we could have seats for everyone. The larger rooms are most times booked far in advance, so we were not able to get anything.

This morning we are going to meet to receive testimony on H.R. 864, which I introduced on January 31 of this year on behalf of the American Ex-Prisoners of War.

I believe that everyone will agree that the House committee has shown its concern for former prisoners of war. In fact, in 1981 we brought forward and passed H.R. 1100, which was enacted as Public Law 97-37. Many believe that the bill did not go far enough, but all agree it was a great step forward for ex-POW's.

For the first time, recognition was given to the fact that many of this group suffered from many problems, including mental problems. Any former POW held for 30 days or more, who ever develops one of the anxiety states to the point where it is compensable under the VA's rating schedule, will be paid compensation. Also, any former POW is eligible for medical treatment for any problem based on his POW status, without the VA having to make a decision on service connection.

Public Law 97-37 also created the Administrator's Advisory Committee on Former Prisoners of War. That committee has been very active and the leadership of that committee is going to testify here today.

H.R. 864 is a further step in attempting to help America's heroes. In light of fiscal restraints that are facing the Congress of the United States, in order to try to balance budgets and keep expenditures down even within those restraints, we are going to do whatever we possibly can to come forth with something. We don't know what we can possibly do at this point. These hearings are a beginning. These hearings may ultimately meet those goals.

At this time I would normally recognize my good friend from New York, Jerry Solomon. Mr. Solomon is not with us at this point and he may come in later on. He is the ranking minority member. However, he is having some difficulties at this moment, but hopefully he will be coming in.

At this time I would like to recognize the great chairman of the Veterans' Affairs Committee for some opening remarks. The gentleman from Mississippi, Mr. Montgomery.

OPENING STATEMENT OF CHAIRMAN MONTGOMERY

Mr. **Montgomery**. Thank you, Mr. Chairman. I certainly appreciate you calling this hearing this morning pertaining to the bill that you have introduced on benefits for ex-POW's. I would like to welcome the ex-POW's here. A number of you had a great deal to do with the passage of H.R. 1100.

When you start naming names, you always get in trouble, but my fellow Mississippian, Earl Derrington, it is good to see him back. The last time I saw him was at the Veterans' Hospital in Jackson, MS. He has made a good, fine recovery. Earl, General Flynn, and others have been so helpful, and I wish I could name all the others there.

Thank you, ex-POW's. You have one of the best veterans' organizations out there. We need your help. We need it for veterans' programs and also we need support for a strong national defense. Thank you for the help you have given us and, in turn, we will try to do what we can to be fair to ex-POW's for the many sacrifices you have made.

Thank you very much.

Mr. **Applegate**. Thank you very much, Mr. Chairman. I concur in those remarks.

At this time I would like to recognize the ranking member of the full committee, John Paul Hammerschmidt.

OPENING STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT

Mr. **Hammerschmidt**. Thank you very much, Mr. Chairman.

I want to join you in extending a very warm welcome to these witnesses here today. You mentioned Mr. Solomon's absence. We heard that he was grounded with a very severe ear problem by his doctor and we don't know whether he's going to get down here from New York, from his district, in time for these hearings. But I assure you that he has a very great interest in this legislation before you today.

Mr. Chairman, I would ask that I be allowed to insert his remarks at this point in the record.

Mr. APPLEGATE. Without objection, it will be made a part of the record.

[The statement of Hon. Gerald B.H. Solomon follows:]

STATEMENT OF HON. GERALD B.H. SOLOMON

Thank you Mr. Chairman. I want to join you in extending a very warm welcome to the witnesses here today. I look forward to today's testimony as we carefully consider this bill to amend the provisions of Title 38, United States Code, on benefits for former prisoners of war.

This is more than just a hearing on H.R. 864—it is an opportunity for continued communication between this subcommittee, the Veterans Administration, and former prisoners of war on important issues.

Mr. Chairman, we should always be especially mindful of the extraordinary hardships our former POW's bravely endured in service to their country. Few men and women have sacrificed as much as they have. Therefore, they should have every opportunity to be heard, and they should be assured of our continuing interest and concern for them.

While this is not an oversight type of hearing, the merits of H.R. 864 go to many aspects of VA benefits for former POW's and the manner in which they are administered. No group of veterans deserve more prompt or understanding attention from the VA than former POW's.

Mr. Chairman, we know that former POW's do not expect special favors. They want fair consideration and we want them to have it. Perhaps, in this context, the larger question is where do we go from Public Law 97-37. We need to know what the latest research can tell us about illnesses related to the POW experience and what further research is necessary so that the subcommittee can properly address the issues before it.

Mr. Chairman, former POW's should be assured of our continued active involvement in matters of concern to former prisoners of war.

Thank you, Mr. Chairman.

Mr. HAMMERSCHMIDT. I am glad to see so many veterans attending this hearing on H.R. 864, because I think the good attendance points up the high level of interest in the benefits which former prisoners of war receive. It also points up something that those who would cut veterans' benefits would like to forget, that the cost of war continues for many, many years after the shooting stops.

Mr. Chairman, this subcommittee has a great responsibility to assure that former prisoners of war have the medical care they need and that they are adequately compensated for the physical and psychological harm they suffered at the hands of our Nation's enemies. Today we are particularly examining whether a presumption for service connection should be extended to certain medical problems other than those already provided for by law. It appears from the written witnesses' statements that we are going to hear some sharply diverse views about the evidence linking some medical conditions to deprivations suffered by POW's.

Mr. Chairman, we may have a difficult task ahead of us in evaluating the evidence to be presented today, so I will conclude my brief remarks to allow us to proceed with the very serious business of this subcommittee.

Thank you, Mr. Chairman.

Mr. APPLEGATE. Thank you, Mr. Hammerschmidt.

At this time, before we get started with our witnesses, I would like to recognize my friend and colleague from the great State of Florida, Mr. Dan Mica, because he has another committee meeting that he has to attend. He would like to be heard at this moment.

OPENING STATEMENT OF HON. DAN MICA, A REPRESENTATIVE IN CONGRESS FOR THE STATE OF FLORIDA

Mr. **Mica**. Thank you, Mr. Chairman.

Just very briefly, I commend you and the subcommittee for holding these hearings. It is, as John Paul Hammerschmidt stated, a very difficult subject and one that does deserve the attention and the focus of this committee. In reviewing the testimony I, too, see that there is going to be diverse opinions.

Unfortunately, there are several hearings scheduled, as we all know, at the same time. I have a list of six questions, Mr. Chairman, as I indicated to you, that I would like to submit for VA response for the record. These questions deal with the status of internees in relation to POW's. But I have a number of questions from my constituents and those concerned about this and, without objection, I would like to submit those for the record.

Mr. **Applegate**. Without objection, they will be.[1]

Mr. **Mica**. Thank you, Mr. Chairman.

Mr. **Applegate**. Thank you very much, Mr. Mica. We will see that Mr. Hagan is presented with those questions, and I am sure he would be more than willing to answer those.

Speaking of Mr. John Hagan, he is the Deputy Chief Benefits Director of the Veterans' Administration, and he will be our first witness today. If you wish, you can go ahead and introduce those in attendance accompanying you, and you may proceed at your leisure.

I notice that your statement is rather short, so I don't think I will really ask you to summarize that. Go right ahead.

STATEMENT OF JOHN W. HAGAN, JR., DEPUTY CHIEF BENEFITS DIRECTOR, VETERANS' ADMINISTRATION, ACCOMPANIED BY HOWARD COHN, M.D., DEPUTY ASSISTANT CHIEF MEDICAL DIRECTOR FOR CLINICAL SERVICES; ROBERT RHYNE, M.D., ASSISTANT CHIEF MEDICAL DIRECTOR FOR DENTISTRY; HERBERT MARS, DEPUTY DIRECTOR, COMPENSATION AND PENSION SERVICE; AND JACK THOMPSON, DEPUTY ASSISTANT GENERAL COUNSEL

Mr. **Hagan**. Thank you, Mr. Chairman.

Good morning, Mr. Chairman, and members of the subcommittee. I am pleased to be here this morning to present the views of the Veterans' Administration on H.R. 864, a bill which would amend title 38 of the United States Code to enlarge veterans' benefits eligibility for former prisoners of war.

I have with me at the table, on my far left, Dr. Howard Cohn, Deputy Assistant Chief Medical Director for Clinical Services, and Dr. Robert Rhyne, Assistant Chief Medical Director for Dentistry. On my far right is Jack Thompson, Deputy Assistant General Counsel. Next to me on my right is Mr. Herbert Mars, Deputy Director of our Compensation and Pension Service.

Mr. Chairman, as you have stated, I do have a very short statement. I would like to start through the statement, highlighting some of what we are submitting.

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[1] See p. 125.

If enacted, this bill would add several medical conditions to the list of those for which service connection may be presumed if manifested to a compensable degree, at any time following service, by veterans who were prisoners of war at least 30 days. The additional conditions are chronic liver disease, organic residuals of hypothermia, gastrointestinal disorders, arthritis, cardiovascular conditions, peripheral neuropathy, immunological dysfunctions, and chronic pulmonary disease. This bill would also reduce from 6 months to 30 days the period of time that a former prisoner of war would had to have been held captive to qualify for VA-furnished treatment for a dental condition or disability.

Mr. Chairman, we cannot support the enactment of H.R. 864. At present there is no consensus within the scientific and medical communities regarding the long-term effects of the prisoner-of-war experience as it relates to the conditions listed in H.R. 864. Currently, certain scientific research is underway or being planned which will lend much-needed insight into this area. Of special note is a morbidity study of prisoners of war from World War II and the Korean conflict which the National Academy of Sciences expects to complete some time during 1986. Until that work is completed, it would be premature to expand the list of presumptive diseases because medical data now available do not show a likely relationship between the typical prisoner-of-war experience and the several conditions in question.

It is doubtful that research studies would furnish justification for the inclusion in section 312(b) of the broad categories of conditions now proposed under H.R. 864.

I would like to illustrate this point. The dietary deficiencies and other hardships which are typical of the POW experience might be found conducive to the development of, say, a particular liver disease. However, the phrase "chronic liver disease" is so nonspecific as to include numerous conditions more likely attributable to other periods of time and other causes. As for those conditions, the scientific studies will be of little help.

Much the same can be said about the several other generic medical conditions included in the bill, such as gastrointestinal disorders, cardiovascular conditions, and chronic pulmonary disease. In short, we believe there must be a recognized nexus between a specific disease entity and the kinds of deprivations which are characteristic of prisoner-of-war internment before serious consideration is given to expanding the current statutory presumptions.

It is pertinent to add that the establishment of service connection on the basis of a presumption is not necessary and not resorted to where evidence indicates a disability has resulted from service. Special consideration is accorded to the unique hardships and privations endured by former POW's, and any reasonable doubt cases are resolved in favor of the claimants.

Mr. Chairman, our position on H.R. 864 does not preclude presumption based upon the POW experience. The Veterans' Administration recommended to the Congress that dysthymic disorders be included in the presumptive diseases applicable to POW's, and this was adopted by the Congress in Public Law 98-223. We would likewise act favorably on any other specific disease entity which may be related to the POW experience.

Mr. Chairman, we recognize dental problems which result from traumatic injury suffered during even brief periods of internments and dental care is authorized on a service-connected basis. Thus, in our judgment, there presently is no sound medical basis for extending comprehensive dental care to all former POW's who were incarcerated between 30 days and 6 months.

Mr. Chairman, that concludes my prepared testimony. I will be pleased to respond to any question you or other committee members may have.

[The statement of John W. Hagan, Jr., appears at p 41.]

Mr. APPLEGATE. Thank you very much, Mr. Hagan, for your statement. I am sure there are a few people in the room who would disasgree with what it is that you have to say.

Let me ask you this: You had mentioned the broad categories of liver disease as an example in H.R. 864, but you concede that the POW experience might be conducive maybe to a particular liver disease. Can you and will you isolate and identify those specific diseases and provide service-connection for them by regulation?

Mr. HAGAN. I would ask that Dr. Cohn respond to that question.

Dr. COHN. Thank you, Mr. Hagan.

Mr. Chairman, let me answer the question by saying generically, where we have problems in the medical arena, is that these terms in the proposed legislation are class terms. In several instances they embody extensive lists of specific diseases. I would draw your attention particularly, for example, to arthritis—I will get to your liver question in a moment.

A recent check of the major textbooks of medicine would indicate that there are no less than 59 discrete arthritides or different types of arthritis. It is this problem which causes us to make the recommendation that we have heard Mr. Hagan make.

With respect to liver disease, chronic liver disease, there are a number of chronic liver diseases. There are a number of etiologies of chronic liver disease. A quick assessment in respect to that would suggest that perhaps there are 20 or 30 different varieties if one includes, for example, the variety of granulomatous liver diseases.

More specifically to your question, yes, I think there are specific liver diseases that could be compensable under this legislation. An example would be chronic liver disease which has as its basis of origin or etiology the virus of hepatitis B. I think that also can be related generically to our feeling that, where there is some evidence—be it historical or from physical examination of an underlying condition—which has caused the veteran or former POW problems through the intervening period, from incarceration or internment to the time that he is seen clinically, I think yes, we can provide or suggest to our colleagues in DVB that service-connection be granted.

Mr. HAMMERSCHMIDT. Mr. Chairman, would you yield before you go to your next question?

Mr. APPLEGATE. Sure, yes.

Mr. HAMMERSCHMIDT. I just wanted to get a little further clarification, Dr. Cohn.

Are there certain types of liver diseases that you could make compensation for administratively? Do you think you could define certain types of liver diseases that you could do without this legislation that we're talking about?

Dr. COHN. Mr. Hammerschmidt, in response to your question, we feel—at least from the Department of Medicine's point of view—that in many ways there is no need for this type of legislation. We believe that we are seeing former prisoners of war and we are assessing conditions that are related or may have been related to the POW experience.

Where I have difficulty is in the class denotation of these various groups of diagnoses.

Mr. HAMMERSCHMIDT. But you say at this time you are administratively making those determinations in allowing compensation for those certain types of liver diseases that you think is attributable to the POW experience?

Dr. COHN. Yes, sir, as we are in many categories of disease.

Mr. HAMMERSCHMIDT. Do you have statistics on how many you have allowed like that, or would you supply it for the record?

Dr. COHN. I think that could be supplied for the record. My colleagues in DVB, I believe, have those statistics.

Mr. HAMMERSCHMIDT. I think it would help our record if you would supply that, Mr. Hagan.

Thank you, Mr. Chairman.

Mr. HAGAN. Yes, Mr. Hammerschmidt.

[Subsequently, the Veterans' Administration submitted the following additional information:]

As of July 1, 1985, there were 31,354 former prisoners of war who were receiving compensation for service-connected disabilities. These former prisoners of war have established service connection for a total of 78,518 disabilities. Of these disabilities, 7,518 are disorders of the gastrointestinal system.

We also have statistics from the Special Issue Ratings System (SIRS) which was established to provide information regarding claims filed subsequent to the passage of Public Law 97-37. As of July 1, 1985, a total of 17,200 former prisoners of war had been rated under the provisions of Public Law 97-37. These veterans have established service-connection for 40,297 disabilities. Of these disabilities, 4,068 are disorders of the gastrointestinal system.

The recurring reports from the SIRS do not provide statistics by specific diagnostic code, such as for liver conditions, but rather by disability group, such as gasatrointestinal disorders. In additin, we have no way of determining from our statistics the number of cases in which service connection has been granted for a disease as the direct result of the prisoner of war experience as opposed to the number in which other factors were the basis for service connection. An example would be a liver or other gastrointestinal disorder which was diagnosed and treated during the veteran's active military service performed after repatriation.

Mr. APPLEGATE. Thank you, Mr. Hammerschmidt.

Looking at the National Academy study that you talked about, there were two things here. You indicated the study would be completed in 1986, and yet we appear to have word that we could expect it before October of this year. I don't know whether you have any other word on that.

Then, aside from that, I think Mr. Hagan had mentioned in his statement that, with regard to the study, it is doubtful that research studies would furnish justification for the inclusion of these broad categories to be put into there. Although you illustrate the point—and I think it is sort of jumping to a conclusion—but if in the event the National Academy studies don't coincide with your thinking, would you then support H.R. 864, or would the Veterans' Administration do that?

I guess that's a two-part question, then, having to do if you have any earlier word on when the study will be completed and if by chance the study would show that our bill is correct, if you would support it.

Mr. HAGAN. If the consensus of the study is that these conditions are related specifically to the POW experience, we would no doubt support it.

As far as the study itself and its completion date, I am going to ask Dr. Cohn if he is aware of any earlier date.

Mr. APPLEGATE. Let me say that you would, regardless of the cost, too, that the Veterans' Administration would support the bill?

Mr. HAGAN. Mr. Chairman, I think the Veterans' Administration has always gone on record as being in support of the payments of benefits to deserving veterans, regardless of the cost.

Mr. APPLEGATE. OK.

Dr. COHN. May I respond?

Mr. HAGAN. Yes.

Dr. COHN. Mr. Chairman, as you well know, scientific data is rarely all or none in character. With respect to the study that was referred to in Mr. Hagan's opening statement, we can identify that for purposes of reference as the fifth longitudinal NAS/NRC study of former prisoners of war. There were four previous studies, and if I may just briefly draw upon those to illustrate for you and the members of the subcommittee the problems inherent in arriving at conclusions. And, by the way, these four studies were published in the years 1954, 1970, 1975 and 1980.

The first study by Cohen and Cooper clearly demonstrated an excess mortality among former prisoners of war in the early years following repatriation. That data was replicated in subsequent studies. Indeed, those same investigators showed increased morbidity among former prisoners of war as compared to the control group.

However, when we look at the chronic degenerative diseases, particularly deaths from arteriosclerosis, malignancies and other disorders that we include under the heading of chronic degenerative diseases, there was no significant difference—that is to say, no statistically significant difference—between the ex-POW's and the control group, the matched controls. That study was primarily performed by Dr. Nefzger, the second study, and later replicated by Dr. Keehn, the fourth longitudinal study.

So here we have within this body of four studies, the cardinal or seminal studies of former American prisoners of war, differing findings. We have the acute finding related to excess mortality, which I addressed; we have the other finding with respect to the development of chronic degenerative diseases. My whole purpose in illustrating this is to demonstrate that, of course, one cannot predict findings from studies, and one must be ready for whatever results one gets.

Now, as to the fifth study, which precipitates your question, no, sir, that study is not to be concluded this October. There is always difference of opinion as to when studies will be concluded and will be published. It is a process, a complicated process, of collation of data, submission of paper to reputable journals, refereeing, et cetera, et cetera.

My personal feeling is that 1986 is being rather optimistic in terms of the finalization and publication of that study. I would personally, if I may, Mr. Hagan, suggest that 1987 is a more likely date.

In response to the second part of your question, no, there is no given. There is never any given in research, that you will find the results that you are looking for. In fact, that's why we do research.

That would conclude my response to your question.

Mr. **Applegate**. Well, I thank you for that. I guess research studies never really come to very definite conclusions. They can only just sort of intimate a lot of things.

I was making reference to a letter that we had on June 7, that Chairman Sonny Montgomery had received from Harry Walters that stated the morbidity study would be completed by the end of fiscal year 1985. That's all I was referring to.

Well, I have some more questions which I will probably submit to you later, and I would appreciate an answer, but I won't take the time right at this moment anyway.

Instead, I would recognize the gentleman from Arkansas, Mr. Hammerschmidt, for any questions that he may have.

Mr. **Hammerschmidt**. Thank you, Mr. Chairman.

Mr. Hagan, is more detailed information available on the VA's cost estimates for H.R. 864 and, if so, would the VA provide it for the record?

Mr. **Hagan**. There is information available and we will provide it for the record.

Mr. **Hammerschmidt**. I think we need as comprehensive response on that for the record as we can receive.

Mr. **Hagan**. All right, sir.

[Subsequently, the Veterans Administration submitted the following additional information]

COST ESTIMATE OF H.R. 864

Fiscal year	Cases affected	Benefit cost (millions)	Man-years	Administrative cost
1986	40,300	$162.8	177	$5,024,000
1987	39,100	157.9		
1988	37,800	152.7		
1989	36,400	147.0		
1990	35,000	141.4		
Totals		761.8		5,024,000

The provisions of H.R. 864 dealing with dental treatment were estimated to cost approximately $6 million over the first five years and will not be addressed here. This analysis deals exclusively with the estimated cost of compensation benefits if the bill is enacted.

Because the bill provides for presumptive service-connection of disabilities arising in several body systems, it was first necessary to estimate the affected population with regard to each disability category. While this analysis will deal only with the gastrointestinal system, the same rationale was applied to each disability grouping mentioned in the bill.

At the time the estimate was prepared, data was available on 11,904 former prisoners of war (POWs) who had filed compensation claims between October 1, 1981, and May 1, 1984. Of that total 5,525, or 46.4 percent, had claimed service-connection for some type of gastrointestinal disorder and had been denied. It was assumed that the same percentage of the estimated total number of living former POWs (88,452 at that time) would have similar complaints of gastro-intestinal disorders. After subtracting the number of former POWs already receiving compensation for gastrointestinal disorders, the potentially affected former POW population with gastrointestinal complaints was estimated to be 37,667.

An analysis of the 5,525 denied claims revealed that 24 percent were denied because no diagnosis could be established for what were essentially non-specific gastrointestinal complaints. An additional 17 percent were denied because there were no current residuals of previously diagnosed conditions such as dysentery. Only 59 percent of denied gastrointestinal disability claims had a currently diagnosable condition, and it was assumed that this percentage would also apply to the entire 37,667 former POWs in the potentially affected population. It was therefore calculated that 22,223 former POWs would have a gastrointestinal disorder that would be service-connected if H.R. 864 enacted.

To arrive at a first-year benefit cost for gastrointestinal disorders, we determined the average annual benefit payment for service-connected gastrointestinal disorders among former POWs receiving compensation ($1,198.90) and multiplied by the estimated number of affected POWs (22,223). The first-year cost for gastrointestinal disorders would thus be $26,644,000. The same procedures were followed for all disability categories in the bill except for immunological dysfunctions, which could not be costed due to lack of data. The total benefit cost for the first year for all categories of disabilities mentioned in the bill was estimated at $162.8 million. For each subsequent year of the five-year cost period that figure was reduced as a result of a declining population.

The estimate for H.R. 864, like any cost estimate, is contingent upon the assumption made. Any change in the assumptions would, of course, change the estimate. We believe, however, that the assumptions made in costing this bill were realistically based on available data and experience. It is significant to note that additional costs associated with service-connected death benefits were not included.

Mr. HAMMERSCHMIDT. Two or 3 years ago you established the POW hot line, at about the time we passed the last POW bill. How do you evaluate the hot line? How is it doing?

Mr. HAGAN. It is a success story. We get a number of calls from around the country asking for assistance. Through the hot line, we are able to contact either a hospital or regional office where we have POW coordinators located. These people are very sensitive to the POW and they immediately get involved with whatever the issue is and get it resolved. So it is a good experience.

Mr. HAMMERSCHMIDT. I appreciate your response from your perception. Of course we're going to ask our other witnesses what they think of it and get an overall view. I congratulate you on that effort that was made down there administratively.

Does the VA have any response to criticism that, unless a former POW has a complete service record, a claim has no chance of approval, even though epidemiological data and known circumstances about conditions of capture would support approval?

Mr. HAGAN. Mr. Hammerschmidt, I am going to ask Mr. Mars to respond to that question.

Mr. MARS. Mr. Hammerschmidt, Public Law 97-37 set up some new procedures for us. In working with the POW committee, we came up with a POW protocol to get complete background data on every one of the POW's and run a very thorough physical examination under the control of a POW physician coordinator at the medical centers.

That law took effect on October 1 of 1981. We started the new protocol examination about a year later. We rated about 10,000 cases following that. We have found that, based upon the change in law in 97-37, that we have either granted or increased almost an additional 16,000 service-connected disabilities for the group that participated.

So that prior to the law, the POW group on our records had about 23,000 recorded service-connected disabilities. Now we have recorded over 39,000. So we believe that through the use of the medical protocol, by having information of the type of experience that the POW suffered, the rating boards and the physicians have sufficient information to find the diseases and relate them to that experience.

Mr. HAMMERSCHMIDT. Does the VA consider longer periods of capture, such as 3 or 4 years, differently than shorter periods of 6 months or less when making rating decisions on individual cases?

Mr. MARS. VA looks at the individual veteran and that individual veteran's experience, because there may be a veteran who may have only been in a prison camp for a short period of 2 or 3 months and may have been somebody that had been picked on by guards and beaten and severely treated, so that we have to look at the individual experience of each of the POW's.

Mr. HAMMERSCHMIDT. I thank you for your responses and for your testimony, Mr. Hagan. I have some other questions but I'm just going to submit them to you and you can respond for the record because we have a number of witnesses. I have another meeting I have to go to at 10 o'clock and we do want to hear our other witnesses. So thank you very much, gentlemen.

Mr. APPLEGATE. Thank you very much, Mr. Hammerschmidt. We will excuse you at 10 o'clock.

At this time I would like to recognize Mr. Wayne Dowdy of Mississippi, who is very fortunate to come from the same hometown as Earl Derrington. Mr. Dowdy has some comments and some questions that he would like to ask.

Mr. DOWDY. Thank you very much, Mr. Chairman. I appreciate the testimony of the witnesses this morning.

I must tell you, after reading and hearing Mr. Hagan's testimony this morning, and hearing the response to questions by Dr. Cohn, and putting that on balance with the statements of Dr. Woodward and Dr. Nardini, it seems to me we've been talking about two entirely different subject matters. Apparently you have reached entirely different responses to the questions posed.

Mr. Hagan says there is no consensus within the scientific and medical communities regarding the long-term effects of the POW experiences. In the statement of General Flynn, he points out that the majority of the medical community has never been exposed in depth to the unique and latent after effects of prolonged exposure to malnutrition, stress, and other associated effects on incarceration.

Dr. Cohn, what is your response to this statement by General Flynn, that we cannot expect a medical consensus, whereas he says the majority of the medical community has never been exposed?

Dr. COHN. Well, indeed, sir, the medical community has not been exposed to a vast array of illnesses, disorders, and strife that their patients are exposed to that they must deal with. That statement is puzzling to me in that regard, the General's.

Mr. DOWDY. As I understand it, you were talking about four studies?

Dr. COHN. Yes, sir.

Mr. DOWDY. And the first one was in 1954 and it made certain findings. The second one was in what year?

Dr. COHN. The second one was published in 1970.

Mr. DOWDY. And the third?

Dr. COHN. In 1975, and then 1980.

Mr. DOWDY. Then the fourth in 1980. And, based on these four studies, you say there is not enough evidence to reach any scientific conclusions?

Dr. COHN. No, sir, I didn't intend to make that specific point. I was using those studies to bring out the point that there can be varying and conflicting findings within well-done, well-controlled, systematically done studies by as august a body as the National Academy of Sciences.

Let me point out quickly that there is a vast body of literature in the world relating to the former POW experience. There is literature in Norway, in other countries in Western Europe. There is Canadian literature.

I might point out that an investigator by the name of Richardson, a Canadian, did perform again a well-controlled study where he matched brothers—that is to say, former prisoners of war of the Japanese versus their brothers who were service people but who had not been incarcerated, had not been interned. He found no difference between those two groups with respect to cardovascular disease.[1] All I'm saying is, the literature is vast and the findings do differ.

Now, to come back to your other point, there is clearly consensus in certain arenas—I do not intend to imply there is no consensus, apropos the statement you have garnered from the other testimony to come. There is a clear consensus in the psychiatric arena, and no one will deny that there is an increased incidence of psychologic and/or psychiatric disabilities in a former POW group compared to matched controls again. No one denies that.

Mr. DOWDY. Let me ask this question: You have talked at great length about the four studies which have already been done by the National Academy of Sciences.

Dr. COHN. Yes, sir.

Mr. DOWDY. You have pointed out that a fifth is now ongoing——

Dr. COHN. Yes, sir.

Mr. DOWDY [Continuing]. And you have said, through Mr. Hagan's testimony, Congress would be premature to do anything until this fifth study of the National Academy of Sciences is completed, you say hopefully as early as 1986—and that may be a little optimistic.

Are you prepared to state that, whatever the findings of this fifth study, that they will be conclusive on the subject and that a medical consensus will have been reached, whatever the outcome of the fifth study of the National Academy of Sciences?

Dr. COHN. No, sir; I can't say that.

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[1] See "POW: Study of former Prisoners of War," VA publication (May 1980), page 145.

Mr. DOWDY. Will it take a sixth? Will a sixth be a consensus?

Dr. COHN. It conceivably could take a number of studies.

Mr. DOWDY. How many studies and how much longer will it take?

Dr. COHN. I am not proposing that we do studies six and seven. I am not taking that position. I am taking the position based on the literature that is now available to us, sir, and we are also saying that there is a fifth study that——

Mr. DOWDY. Would it be a correct statement of what I understood your testimony to be here this morning, that there has been four studies by the National Academy of Sciences and they have been conflicting; you have said let's wait on the fifth study?

To me, it appears to be that the VA is saying let's wait and see what that study says and whether we agree with it before we think that one will be conclusive.

Dr. COHN. Sir, there is a body of data—and I truly hope this is responsive to your question—there is a body of data sitting out there. We have conducted, through the protocol that Mr. Mars alluded to in his remarks, 17,000 examinations of former POWs with a new standard protocol since June of 1983. That body of data exists out there and has not been analyzed other than by a tracking system that has followed the course of the POW through the examination process.

What I am saying to you is that the actual data, the diagnoses, the laboratory studies, et cetera, have not been. We are on the threshold of doing that in collaboration with the NAS. That is essentially the fifth study, if you will.

It would seem unfortunate to me, from a clinical, from a scientific point of view, not to have the benefit of seeing that data, of analyzing that data, to make further judgments when there is, I think, a truly valid and honest difference of opinion in these arenas that we're discussing in this proposed bill.

Mr. DOWDY. OK. Thank you, Dr. Cohn. Let me say, though, that I can understand the frustration that the POW groups have expressed to me.

Mr. Hagan, let me ask you a question on another subject. I know your Department and the Board of Veterans' Appeals is separate, but I wonder if you can tell us whether or not they are doing better in the time limits of their decisions. This committee recommended legislation which became law to add 15 new members, as I recall, to the board. It should be helping them to cut into the backlog.

Do you have any information which you can give us at this time on this, please?

Mr. HAGAN. Yes, I do, Mr. Dowdy. The Board of Veterans' Appeals has established additional boards. They have also set up special boards for handling POW appeals. I am told that on the completion of the action within the regional office for referral of an appeal to the Board, that they are calling cases up in about 15 days. So I would say they have had great success through the committee's generosity in allowing them to pick up the additional personnel to establish additional boards.

Mr. DOWDY. That's all I have, Mr. Chairman.

Mr. APPLEGATE. Thank you very much.

Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. Thank you for yielding me a little bit of time here. I just want to apologize to the witnesses that I'm going to have to leave. I want to thank them all for being here, but I particularly wanted to thank General Flynn for his leadership in this area.

Mr. Molinari from New York is now here on our panel, so thank you very much, Mr. Chairman.

Mr. APPLEGATE. Thank you, Mr. Hammerschmidt. I am happy to see Mr. Molinari.

Do you have anything you would like to add at this particular moment?

Mr. MOLINARI. No, sir. I apologize for being late. I think it would be appropriate if I sat and listened at this time. Thank you.

Mr. APPLEGATE. Thank you, Mr. Molinari.

I want to say to Mr. Hagan and his colleagues, thank you very, very much for coming in and talking with us. We appreciate your presence, always.

Mr. HAGAN. Thank you, Mr. Chairman.

Mr. APPLEGATE. The next witnesses will be a panel comprised of the chairman and two members of the Administrator's Advisory Committee on Former Prisoners of War, Lt. Gen. John (Jack) Flynn, a former prisoner of war for 5½ long years in Vietnam; Dr. John Nardini, and Dr. Theodore Woodward. I would add that Dr. John Nardini also was a former prisoner of war.

Gentlemen, I welcome you to the committee this morning. General Flynn, let me say that I do have your statement and it will be made a part of the record. If you wish to summarize, I will leave that within your hands.

STATEMENT OF LT. GEN. JOHN P. FLYNN, CHAIRMAN, VA ADVISORY COMMITTEE ON FORMER PRISONERS OF WAR; JOHN E. NARDINI, M.D., AND THEODORE E. WOODWARD, M.D., MEMBERS OF THE VA ADVISORY COMMITTEE ON FORMER PRISONERS OF WAR

General FLYNN. Do you have my written testimony, sir?

Mr. APPLEGATE. Yes.

General FLYNN. I think the people here in the room, the audience behind us, are very familiar with the position stated therein. Of course, the VA is very familiar with our position.

I would like to make a few preliminary remarks concerning our relationships with the VA. We, of course, thank you for inviting us up here and for the opportunity to present our views.

Our role is not an easy one. We have a responsibility to four separate constituencies. The first is to the Congress—that's why we're here; second, to the Director of the VA; third, to his staff and to the field, and finally, to these gentlemen back here in their red coats and their wives.

We have emerged from this relationship with considerable respect for the people that work in the VA, the professional people and administrative people. We have enjoyed working with them. They are overworked, under an austere budget. We appreciate their role—we don't envy it—but we thank them for it.

We do have honest and open disagreements. These have been well established. They are public and they have been aired. You have heard one side of it, and now we will consider the other side of it. These disagreements chiefly are in the area of medicine. We have with us today two very distinguished members of our medical subcommittee, Dr. Jack Nardini, who is suffering from cancer and left the hospital on Thursday to be with us, and Dr. Ted Woodward, who is also distinguished in his own right and, incidentally, was one of the teachers of Dr. Howard Cohn who has presented testimony here.

I would like to just briefly touch upon those NAS studies, the four which were mentioned. One of the problems that we have with those studies is that, as I recall, it took 4 to 7 years from the time these studies were initiated before they were available for publication.

Concerning the hot line, we fully support that. We were the people who recommended it. It has served the purpose of not only identifying to the VA pockets of poverty out there, but it also permits our constituency, the POW's, the opportunity to ventilate their feelings. We suggest it be proliferated into other areas.

About some of the statistics which we have heard, out of a total of 39,311 claims, 30,000 of those claims were awarded 0 to 10 percent disability. They chiefly come, as was pointed out, for neurological and psychiatric disorders. The issues which we are talking about are more substantive in terms of body ailments. I'm not quarreling, that psychiatric disabilities are not significant. They are most significant.

In the interest of time, I shall first ask Dr. Nardini to make his statement concerning our position relative to the Veterans' Administration.1

[The statement of Lt. Gen. John P. Flynn appears at p. 42.]

STATEMENT OF JOHN E. NARDINI

Dr. NARDINI. Members of the Subcommittee on Compensation, Pension and Insurance. I would like to expess my appreciation for being provided the opportunity to address this committee on this important and urgent issue of consideration of compensation for illness of diseases incurred from prolonged prisoner of war conditions.

I am John E. Nardini, M.D., captain, U.S. Navy, retired, in active practice of psychiatry and neurology in Washington, DC. I have been in continuous practice for 47 years—23 as a regular Navy medical officer, retiring with the rank of captain, and 24 years in private practice in Washington, DC. in neurology and psychiatry.

On April 9, 1942, while serving as battalion surgeon with the U.S. 4th Marine Regiment on Bataan, Philippine Islands, I was captured by the Japanese Imperial Army and held as a prisoner of war for 3⅓ years to the end of World War II. During that period of time I functioned as a medical officer for my fellow POW's and observed and worked in the midst of universal sickness, deprivation, misery, and widespread death.

I wish to fully support and speak in favor of H.R. 864, which represents a long-overdue correction of failure of needful help to a small but significant, now aging, group of former POW's. It should be emphasized that this group is asking for nothing more than the law provides and to which they are entitled.

Now, expert. I hate the term "expert" because, first of all, an expert is supposed to know everything, and it seems to me hardly anybody knows anything. Anyway, when I came back from overseas, I was repatriated and had to make up my mind whether to devote my life to the destruction of the Japanese Empire or get on with my career. I found I was no match for MacArthur, so I stopped and wrote a lot of papers and that was the beginning.

I worked with and helped many POW's who came back and became very familiar with them. They found me, and I became even more familiar with the post-POW experience.

Then it seems like the world must get into wars, and every time there is a war there's got to be POW's. I was still on active duty when the Korean war was going on and did work with the Korean POW group. Then the Vietnam war came along and I was called by the Surgeons General of the Air Force and Navy to consult for them, which I did for the next 4 or 5 years, in helping to get protocols ready for them and to adopt them when the Vietnam POW's came back, and by this time I had a pretty good grasp on prisoner of war technology and we worked very extensively on this program and problem.

Then the next thing that came along was the Advisory Committee that I have been working with for the last 4 years. This has brought things back into the picture.

In addition to this, of course, I have read extensively in local literature, U.S. literature, military literature, and foreign literature, which I will present to some extent a little bit later.

Now, the peculiar phenomenon here is interesting and confusing. The VA had the authority to pick the medical members of the Advisory Committee, and they picked them presumably very carefully with the idea they were picking experts. We did have six medical members—we now have five. Dr. Woodward was going to present some of the detailed medical material for you which will clarify some aspects of the technical aspects. He has been professor and chairman of the Department of Medicine at the University of Maryland. Dr. Paul Beason is a dean of American medicine who has been chairman and professor of medicine at Yale and Oxford and has edited the textbook that is circulated in American medicine. The other members are equally distinguished in certain areas.

In the beginning, I guess we would have to say that some of the members were a little less versed in the intricacies and the special aspects of POW problems, but as we gathered more data, as we discussed more information, and with their background in medicine and their good brains, we have all come to, over the years, to a definitive absolute conclusion that the recommendations we are making in regard to these items of health are perfect to the exposure experience that the POW had over the years.

Now, this question of consensus, I have raised that question over the years in the meetings and there has never been a response. The only consensus that exists that I know of about POW's as a whole is the consensus that this very excellent body of physicians has determined. It is sort of like physics. There is matter and antimatter. I don't understand it because antimatter is supposed to be up there somewhere doing something, but you can't see it, you can't find it, and you can't identify it.

So that's where the VA consensus situation is. There is no consensus out there. The only consensus that I know about is that represented by the group we are dealing with.

Another simile is like in space where those pieces of information are going to present to you a vast amount of material which is highly supportive of the consensus, and you can't just say there is no consensus by just saying it. You have got to find something to oppose what the positive offerings are, or offer something else in its place.

Now, part of the problem is medical. For I don't know how many years, probably 30 or 40 years, the consensus was—the consensus can change, of course—the consensus was that radical mastectomy was the only thing you could do to save a woman suffering from breast cancer. That perception was changed and people tried more modified operative procedures and they have found, to their surprise, that it's pretty good. So now the consensus has switched 180 degrees.

Another problem in the medical aspect is that doctors like to be right, especially now that there are so many lawyers around. For example, a patient comes in with a sore throat, it's red, the patient has been in contact with another patient who had septicemia, a streptococcus sore throat, it's sore, they're sick, their temperature is high. Some doctors won't do anything until they take a smear to find the organism and then get a sensitivity test and then go ahead with the treatment. Others will go ahead with less than that. But doctors like to have all the data hard. As a matter of fact, most of the patients that most doctors see, they don't have hard data. They don't have hard diagnoses. So they have to work on a presumptive basis.

Now I'm going back and hit you on the head hard with a sledgehammer, because I don't know any other way to make this impression. It did not impress the VA. It impressed our members, but it has never impressed the VA. I don't understand that. Let me just read one little paragraph here.

There is ample evidence in the published literature with statistical evidence to support the concept that extremes of physical and mental stress and deprivation attribute to death-shortened life, increased incidence of disease, and a lessened quality of life. We believe ample evidence exits as to the probability of current disabilities experienced by former POWs being caused by their service. Within the VA doctrine of reasonable doubt, we are of the opinion that presumption of causality should be extended for former prisoners of war who have been demonstrably exposed to excessive and prolonged stress and deprivation to include those categories listed in the act.

Now, let me just make one statement. I was there and I was deprived. I had beri-beri, I had scurvy, I had pellagra, I had TB. My weight was down to 80 pounds. I worked every day, chronic dysentery. I was sick, they were sick. It was very hard to draw the line. The point I want to make is that all of the survivors, certainly in Korea, and all of the survivors in the Philippines, were at death's door. There isn't any question about that. There was no one who escaped. The psychological side of it is amazing to me because we have always had a hard time promoting psychiatry and psychiatric divisions, that somehow or other it has surfaced so that it has been more recognizable than the physical. You cannot get down to a skeleton and stay like a skeleton for weeks and months, and in some cases for years, and not damage the body.

Dr. Woodward has an excellent paper to present on this with much more medical certainty. Mine is observational and there isn't any doubt in my mind when you get down to the skeleton and stay a skeleton for a long time, that the body is attacking itself. It dissolves itself, and some of the cells will never be repaired. I have seen many survivors, and many seem to have done all right. But when you probe and get into it, there is an infinite variety of both physical and mental and emotional symptoms which they have lived with and paid a great price for. No member of that group, of either the Korean or the Pacific group, has escaped both physical and mental and emotional difficulty. I have never seen one, and I have seen thousands, and hundreds and hundreds and hundreds have died in my hands. I know the situation.

Another thing about diagnosis, we like to have a nice, clean-cut diagnosis. But actually there are many factors that come into it. Demography. If a man lives in a sewer, he is much more likely to have a certain different set of diseases than if he lives in a mansion on the hill. If he is a homosexual who is highly promiscuous and practices his trade, he is much more likely to have AIDS disease and die therefrom as opposed to the nun who stays in the nunnery. So demography is important. These guys were in the wrong place. You can't be in a place like that and not get hit and hit hard forever, as far as I'm concerned.

Epidemiological factors, this has to be considered. Again, most diseases are not nice, clean-cut. Epidemiological processes, this is a key thing. If you are in a certain place and you're exposed to certain things, the incidence of the exposure of those things is going to influence what particular diseases you get. If you're in a place with no sanitation, you're going to get dysentery. When you're in a place where there is no medication for malaria, you're going to get malaria. So the epidemiological basis is an important area.

Now, I am using this present format to highlight a few of the multiple areas of questions and issues that coalesce into an impressive array of data and opinions that point to a reasonable conclusion—and I'm well aware of what happened to Socrates for asking so many whys.

Why did 40 or 50 percent of the POW's in the Philippines and Korea die in the 3½-year period? What happened to their bodies that brought them to death? They nearly all died as human skeletons. In this case, it was to be presumed that the body was so damaged and weakened that life could no longer go on. I was there as a physican and they died under my infinite care. Men who did not die were most of the time identical in appearance of emaciation and disease.

Why do we assume that the bodies and the psyche of the survivors were and are left unscathed? Why is the death rate of World War II far exceeding the death rate of the general VA population?

These were proven survivors. Why did they die before their non-POW peers? They were a hard fighting people and there was never a lack of courage in their dealings with their illnesses and their troubles.

Why does the burden of proof fall on the surviving ex-POW and their protagonists, where they have to prove a causal relationship to their physical and mental deficiency that stems from known extreme deprivation? Isn't it as reasonable that the others, in this case, the VA, should provide an explanation of how the human body and mind can be so physically and mentally traumatized and could not be damaged?

Let it be understood that all POW's were exposed to mostly all the same conditions. Why do former POW's have a higher incidence of service-connected disabilities? Why do former European theater POW's show significantly higher disability than other World War II veterans in the same theater? Why is the most prevalent service-connected condition of former POW's anxiety neurosis? Why have foreign governments accepted the causal relationship of POW experience as evidence of later physical and mental deficiencies in ex-POWs and provided compensation without the individual having to prove "scientific relationship"?

Why do former POW's have a significantly higher incidence of more severe disabilities than non-POW veterans? This is a matter of record. Why do former European theater POW's who are hospitalized for malnutrition have an increased rate of mortality due to trauma, tuberculosis, and cirrhosis while these POW's without malnutrition have no increased rate of mortality?

Why did the NAS study in 1965 show a significantly greater percent of former European theater POW's over non-POW veterans being compensated for service-connected disability for the following conditions: malnutrition, avitaminosis, arthritis, residuals of frozen feet and scars, and anxiety neurosis.

Why did the former Pacific theater POW's have a statistically significant higher death rate from tuberculosis, accidents, and suicides for the first 5 years after liberation as opposed to the non-POW Pacific theater group? Why did Nefziger find that in 1953 to 1965 tuberculosis continued to be the major significant cause of death, along with cirrhosis from the Pacific theater POW group? Keehn confirmed these findings but not until after the midfifties.

Why did the former Pacific POW's manifest a significant morbidity rate from TB and other infectious diseases as well as nerve inflamation neuritis, gastrointestinal, gastrourinary and orthopaedic problems and prevalent arterio-sclerotic heart disease through 1965?

Why is the most recent showing that the Pacific theater POW suffers from a significantly greater amount of service-connected disabilities than the matched group in the general veteran population? Why are the findings similar for Korean veterans who suffered the same types and degree of deprivations as the Pacific World War II POW's?

The available mortality and morbidity data on the types of severity of former POW's from repatriation to the present time indicates that the congressional concern about former POW's, especially those of the World War II Pacific theater, have a significantly higher incidence and greater variety of diseases attributable to the internment is well founded. Evidence to substantiate this concern comes from the National Academy of Sciences and the VA mortality and morbidity data itself.

Concerning the severity of former POW disabilities, it would show the Pacific ex-POW's are the most severely disabled POW group, followed closely by the former Korean POW's.

Why do Entinger and Strom in a 20-year follow up of Norweigan political prisoners and civilian resistors deported to Germany during World War II report a significantly higher morbidity and mortality rate than the prisoner group as compared with the general Norweigan population? Why would Canadian POW's in the Far East, as Fisher found in post mortem examinations of 11 Canadian POW's performed 4 to 7 years after liberation?

Why in a 19-year follow up study of 100 Canadian POW's of the Japanese matched with their brothers of World War II wartime service were 95 out of 100 POW's granted a pension entitlement by the Canadian Pension Commission, as opposed to none in the non-POW brothers match? Why, if there is increasing current evidence of immunological deficiencies resulting from stress, is this not applicable to POWs during that period? Why could not this stress factor have contributed to a high morbidity and mortality rate?

Why is it not to be expected that past severe prolonged physical and psychological trauma could generate more disease and death? This entire matter cannot be comprehended without fairly understanding the epidemiological significance.

Why is the situation with amputees any different? A study was made of amputees, Vietnam veteran amputees, that they developed a higher incidence of certain other diseases, such as increased blood pressure. There has never been any consensus, never been anything to indicate that this was a significant thing. Well, if it applies to a group such as the amputees, it could very well apply to this other group which had an entirely different type of exposure.

Why is it postulated now that many Ethiopians who have been starving and then surviving experience permanent damage and they are expected to live shorter lives?

In terms of epidemiological consideration, a significant discourse occurred one time with some of the members of the committee and myself and the director in which we were trying to establish the epidemiological basis for this factor that some of these things occurred. The then medical director said—and I use as a similar example smoking. It is generally accepted that smoking can cause cancer. Well, it is true there has never been an individual instance of smoking that can be pinpointed and you say that causes cancer. But we do have statistical evidence, which is epidemiological evidence, accepted by most people, that the then medical director said he did not accept the epidemiologic basis of statistical evidence as smoking causing cancer. I could only assume that that had some influence in terms of the VA attitude.

Just a few more points and then I'll stop.

If one accepts the demographic and epidemiologic data as valid, significant, and an essential part of medicine, the considerable statistical support of statistical data in the previous material presented, and through the intent of Congress and the express practice of

VA regarding benefit of doubt, on the side of the POW, the conclusion would be obvious. If it be true, that this small group of survivors were subject to severe prolonged physical and emotional stress; if it be true, that statistical evidence supports a clearly high risk of physical and mental illness than their veteran counterpart, and it is clear and demonstrable; if it be true that demographic and epidemiologic evidence of higher incidence of disease and death is clearly evident in this group, and this has been clearly demonstrated; if it be true that demographic and epidemiological factors are a legitimate part of medical thinking and practice, and these are denied, then we're flying in the face of logic and entering a "no-think" state which is mentally primitive and ultimately catastrophic.

The position we have taken is not an isolated one. Medicine is, at best, an inexact science. I have spent my whole life to recognize logic and live by it. As a psychiatrist for many years, I have seen what happens when people lose their logic and react accordingly. I cannot abandon a position of logic. Let those who abandon logic set forth their contravening explanations other than arbitrary denial. I, for one, cannot back away from the predominant weight of medical evidence and must therefore give credence to this position.

Thank you.

[The statement of Dr. John E. Nardini appears at p. 50.]

Mr. Applegate. Dr. Woodward.

STATEMENT OF THEODORE E. WOODWARD, M.D.

Dr. Woodward. Thank you, Mr. Chairman.

It is a privilege to present my data to you. I have been privileged to serve on this committee since its inception. I am not a former prisoner of war but had 6 years experience as a veteran, as a medical officer, and 4 of those years were overseas. I did have the opportunity to deal with very deprived persons.

I just presented to the chairman some pictures that I personally took in Manila. I cared for 500 such persons after Manila fell.

There are three other nonformer prisoner-of-war physicians on the committee other than Dr. Nardini during our 3 or 4 years of deliberations. We had the opportunity for the advice of seven other physicians, plus consultants, including Dr. Beebe, who was the author of one of the reports mentioned this morning.

I had no idea of the magnitude of this problem and hadn't thought much about it, but I can say that over the last several years I have learned a lot. I consider it a real opportunity for me to have worked with these able men, very dedicated Americans. I share all of the trials and tribulations that they went through.

Now, we have fomulated—"we" meaning the non-prisoner-of-war members of the committee—have formulated a statement which appears on pages 1, 2, and 3 of my report, which I will not take the time to read. I would like to say that I believe any other five physicians of the background and experience of persons such as myself, Dr. Beason, Dr. Kuhn, and others, would come up with the same medical consensus. The consensus is that we have formulated those words.

I will not read the seven disease categories which were listed. Item No. 5 does mention hepatic disorders, and I will consider them in my brief comments.

I do not plan to give you gentlemen a lecture on medicine, although I attempted to as an old, worn-out professor. I would like to say that sometimes things are black and white and that's clear, and sometimes they're gray, and that is what we are now considering, gentlemen, something which is gray. Reasonable doubt has been used.

There is no question of the relationship of stress and illness. Stress means extremes of temperature. Sometimes there are stresses with different sexes, ages, the endocrine or chemical balances of our body, whether we have a foreign body or not and whether we use as little alcohol as any one of us might use after this session today, small amounts of alcohol can at times have deleterious effects upon the disabled body.

Simple examples of the deleterious effect of temperature and infections. The great Pasteur walked into the Academie Franciase years ago with three chickens. Two were dead and one was living. He had injected them with anthrax germs. The living chicken had been injected and kept at room temperature, but the other chickens had been injected and kept in the cold, and they were dead chickens. All I as a physician know, if I have a patient with pneumonia and has no fever, then I'm going to have a patient who is going to do badly. We're talking about all kinds of extremes that our former prisoners of war went through.

What about anxiety, fear, fear of death, panic and the relationship of disease? A great physiologist by the name of Riach took some monkeys, not far away at Walter Reed, and he made them anxious through devious methods that I won't mention. But I can tell you that the monkeys which were put under stress developed ulcers of the stomach. There is no question of the relationship of stress causing increased gastric secretions, stomach secretions, if you will, and ulcers.

Burn patients who are stressed develop ulcers. Anyone who is excited develops increased secretions of his stomach and has diarrhea, hypermotility of his intestine.

I'm not going to lecture on nutrition. I would like to think that everyone in this room has the privilege of two eggs a day—I'm not a cholesterol nut, Mr. Chairman—and some milk and some meat and cheese. That's about 70 grams of protein. These former prisoners of war didn't see protein. They had soup that was mostly mud, and greens at times.

Now, there is no question of the deleterious effects of malnutrition on body function. If you look at the picture, picture number one that I have presented you—that man, incidentally, did not survive; others did. But when we are malnourished and we lose water, we also lose something called calcium and sodium and phosphorus and potassium, and when we lack potassium we are weak and under those conditions your heart can stop, or it can skip and do many things.

The great physiologist, Paul Cannon of Chicago, pointed out that malnourished people don't form antibodies. Antibodies make you and me resistant against disease. He also pointed out that when we're malnourished the blood cells in our bodies don't mature and we need blood cells, leukocytes, to fight infection. Even malnourished people have less copper in their body—and I can't take the time to discuss what that means. But when we have malnutrition, plus infections and draining wounds or diarrhea, everything falls apart. The wound heals poorly. We have delayed bone callus. We don't heal bones. We are predisposed to hemorrhagic shock. Our resistance to infection is down, and something very important and ignored in the medical literature is something called acidosis. That means the body has too much acid in it. And when you are malnourished you have acidosis. Then you can get wet lungs, or you can develop all kinds of breakdowns of the connective tissue of the body. The connective tissue of the body is our matrix, our foundation, that's our steel structure.

Incidentally, that is what rheumatoid arthritis is all about. We don't know the cause of rheumatoid arthritis today. The man who discovers it can sit down and relax. We don't know, and we don't even know how it is started. But we do know that when the connective tissue of the body is broken down, and then there's an imbalance of our chemicals and our hormones and our vitamins, simple vitamin C, then we know the connective tissue suffers. What are the long-term effects of that? God only knows. You can't prove it, but you can't disprove it. That's the gray part of the argument.

These men and women under this privation for 2, 3, or 4 years, without anything to eat, with interminable gastrointestinal infections, if you look at their intestine the lining was a flat as a pancake, and yours and mine are very fluffy. They are called villi. Many of those things carry over into later life. And how does it manifest itself? Diarrhea, mushy bowl movements, irritable colon. There is no way to prove that on an X-ray or on a laboratory test, but it's there. That's the gray part.

Malnutrition in its extreme affects four body systems: the central nervous system and the peripheral nervous system. One of the pictures you see before you, picture No. 2, is a patient who had what Dr. Nardini had. Patient No. 2, you can see his feet are dropped. He had foot drop. That was vitamin B1 deficiency. You see the legs are a little swollen. That means he had protein deficiency. And you see the rash, he had pellagra. That is classic beri-beri, peripheral neuritis.

Now, then, you get over that. Sometimes you don't get over it completely. But I do know, having witnessed it myself, that every prisoner of the Japanese developed the symptoms of beri-beri within 6 months of his incarceration. What are the long-term effects of that down the line? What does that have to do with the effect of the brain and nerve cells? We don't know. Your cells in your body, sir, have a certain time to live, as do mine. We don't get new brain cells. But what is the effect of extreme malnutrition for 3 years, plus deprivation of vitamins and other chemicals on the life of that cell? We don't know.

But anyone in good judgment would say that deprivation had a deleterious effect upon the life of that cell. All one has to do is read the remarkable writings of Dr. Louis Thomas of the Rockefeller Foundation.

Malnutrition affects the inflammatory reaction. We don't respond as well. It affects the liver. Someone who injured his or her liver during incarceration may have gotten over it, but some, through a reaction we in medicine call an antogen antibody reaction, may go on to something called chronic hepatitis. We know they are more prone to cirrhosis of the liver. We know they are more prone to hepatoma. And if you put a little bit of alcohol on that, not the alcoholic type of intake, then that is an additional extra damage and sometimes that is very, very hard to measure.

Malnutrition has an extreme effect on the muscular system. Witness patient No. 1. His glycogen stores are gone. That meant he had no source of sugar. You have some glycogen in the liver.

The heart is muscle. We cannot even today answer the question of what are the long-term effects of beri-beri heart disease. There is not a pathologist in the United States that can look at a heart and look at the microscopic sections and say that is or is not beri-beri heart disease. But the medical profession knows there is an entity called beri-beri heart disease. It is unquestioned. But some things you can't prove. That is the gray part.

Now, I mentioned some of the long-term effects. Beri-beri heart disease is an example. I mentioned the effect on the connective tissue. I wish I, as a physician, were more informed, that I could explain what rheumatoid arthritis is, what lupus erythematosus is. These are the connective tissue diseases. We don't, at this state of the art, know the cause. We cannot add for sure what the early effects might or might not have been.

I mentioned acidosis as an acute disorder of the connective tissue. Again, the connective tissue is the foundation of our bodies. The long-term effects have not been blueprinted, and that includes rheumatoid arthritis, which probably involves a number in this room. But I can't believe, as a practicing and teaching physician, that someone who was deprived for so long of nutrition, protein and minerals, and then was in the extremes of hot or cold, there might not have been some bad effect down the line.

As far as arteriosclerosis is concerned, gentlemen, that's a gray zone. Today in 1985 we don't know what causes arteriosclerosis, cholesterol. We don't know what the effects would have been of this deprived period. We don't know. Is there a relationship? That's the gray zone.

Now I would like to close by reading what is consensus. This is consensus among our various committee members and with any physician that I have discussed this with.

With respect to debatable disability disorders of former POW's, such as arteriosclerotic conditions or rheumatoid arthritis, compensation should be allowed if: That veteran never fully regained normal health after imprisonment and he or she experienced abnormalities of the heart or vascular system—such as coronary artery disease, stroke or hypertension—or the connective tissue system—such as rheumatoid arthritis—on a continuing or repetitive manner during the ensuing years. We believe the benefit of the doubt should be in favor of that veteran.

Now let's get to the gray area—and I'm closing, sir. In certain extenuating circumstances, adjudication should be decided on an individual basis. Conceivably, a former POW returned to military service or civilian life and enjoyed an extended period of good health with freedom from clinical manifestations of arthritis, intestinal disorders, or heart disease, including angina pectoris. After this extended period involving years of good health, gainful employment and normal social adjustment, clinical manifestations involving the aforementioned body systems may have occurred for the first time—that could occur with any one of us today. Under these circumstances, individual consideration of all factors, the medical history and physical findings, social, emotional, demographic and epidemiological—all that Dr. Nardini mentioned—are to be applied before a claim is denied. There may be some circumstances in there which would want a rater to make a judgment in favor of that POW.

Gentlemen, we are here to openly discuss an attitude about a matter for which there is no precise blueprint. The problem we share with you merits unstinting attention by everyone concerned. This includes the public, which has little insight into the issues at hand.

Thank you.

[The statement of Dr. Theodore Woodward appears at p. 103.]

Mr. APPLEGATE. Thank you very much, Dr. Woodward, Dr. Nardini and General Flynn. Your articulation of a very complex subject matter in very graphic and medically technical terms was fascinating and very educational to me, as I am sure it was to the other members of the panel. I appreciate your being here.

I did have a couple of questions. However, we are pushed now for our vote and we will have 15 minutes to go over there. But I had two quick questions, and whether your can answer them now or get an answer to me, it just happened, General Flynn, that you had mentioned an area of H.R. 864, in your positions on 864, you talk about that you would have two qualifying conditions for eligibility that would be imposed. I assume that regardless of whether they were in there or whether they weren't, you would support 864.

General FLYNN. Yes, sir.

Mr. APPLEGATE. But you lay one down there that's pretty strong, the first one about "location is known as one where conditions of captivity were manifestly harsh and characterized by such things as physical violence, torture, executions, enforced hard labor," and then you give as examples the Philippines and Japan.

If that was in the law, would that have any deleterious effect, let's say, on those who were prisoners in Europe? In other words, you're drawing a——

General FLYNN. Yes, sir, in one of my statements I pointed up that the total POW population is roughly 85,000. Of this, all but 10,000 are from Europe and Africa. When we structured the formula, which you have before you, I assumed that 20 percent of the European population would be eligible and 80 percent of the Far East population. That's a guardhouse estimate, but I think you will find it's fairly correct. When you apply those two, you have 25,000 eligible for costing estimates.

Now separately from cost, as to the first condition, under the harsh circumstances and so forth, the areas are pretty well recorded. The second condition, you must show the symptomology of these diseases, you understand that.

The imposition of these two conditions does not mean that these men, the balance that do not fall in the category, are ineligible. It is simply that there is more doubt concerning them than the candidates which we have identified. They still go through the POW system. We find—and again, it is our estimate for costing—that that 25,000 we have been talking about is pretty closely related to those number of people that come in. Remember, of the total of 85,000, a great number do not choose to come in because they are not ill, because they prefer private medical facilities. They have other arrangements. But the chief reason is they usually don't have that need***the symptoms.

Does that answer your questions, sir?

Mr. Applegate. Yes; I think so.

General Flynn. Mr. Chairman, I would like to state our appreciation for having the opportunity to appear. I regret somewhat that I yielded on the oral statement of my position because it is more definitive, but I know that you gentlemen have it well in hand and we are greateful. God bless you all.

Mr. Applegate. Thank you very, very much for appearing before the committee. We have a tremendous respect for each and every one of you and look forward to having you come back and work with you in the future.

I would first like to recognize Mr. Molinari from New York.

Mr. Molinari. Mr. Chairman, I have one or two questions, but I think in view of the pressing time for us to get to the floor, if the panel wouldn't mind waiting, we have about 10 more minutes to vote and then we have 5 minutes, I assume, after that. So it would be about 15 or 20 minutes.

Would you gentlemen be able to remain?

General Flynn. Sir, we would be delighted to.

Mr. Molinari. Fine. I would appreciate it.

General Flynn. We do have other matters concerning cost. Our experience with what we have seen so far is there are problems.

Mr. Applegate. Then we will temporarily adjourn our meeting until we are able to go over and vote and come back.

[Wereupon, the subcommittee was in recess.]

Mr. Applegate. Why don't we get the meeting started again. When we temporarily adjourned, the gentlemen from New York, Mr. Molinari, had a couple of questions that he wanted to ask.

Mr. Molinari. Thank you, Mr. Chairman.

First, I think it would be fitting if I paid tribute to the three witnesses. I think the caliber of testimony we heard this morning was excellent, and sobering in some respects, but it at the same time answered in advance a lot of the questions that we might have.

I think it goes without saying that our ability to pass legislation that would call for new dollars would depend upon the cost and the number of dollars involved. The Congressional Budget Office has not done a full and complete study, but they have done a preliminary study and they are coming up with some figures which may be adjusted upwards, but $40 million is the figure I have heard this morning. And yet in the testimony we have heard that it could be $167 million the first year.

General Flynn, or any of the witnesses who might feel competent to answer the question, do we have any epidemiological studies that we can look to to get a better cost estimate?

General FLYNN. I don't know that answer, sir. Perhaps one of these two gentlemen could answer. I think we could search for that.

May I make a comment on costs?

Mr. MOLINARI. Sure.

General FLYNN. I am not only an ex-POW, sir, but I have been in the Pentagon for 5 years, and of the two experiences, I think I prefer Hanoi. In that role, working there, I was in plans as Inspecting General, and I became very familiar with cost estimates. It comes as no news to you gentlemen that cost estimates are very sensitively related to underlying assumptions.

The VA cost estimates of this law were based upon the following assumptions: they took the population and they established it at 85,000 living POW's. Then they selected a disease, whatever the disease might be—go to the records and find that of the 85,000 total, 10,000 had tried to establish claims for that particular disease, and of that total of 10,000, 5,000 were awarded—in other words, 50 percent.

Then they go back and they apply that 50 percent to the 85,000 ex-prisoners and assume that 42,500 would receive disability. While there might be a logic in that, I have yet to be able to determine what that logic is because it is axiomatic, that the people who have the symptoms are likely to come in, those that don't, won't. This is improper sampling.

It is commonly held in the Washington area that if you want to kill a program, you overcost it, and if you want to push a program, you undercost it. Now, I am in no way accusing the VA of that sort of thing. In fact, we, the committee, are on record that we believe the opposite is true. That's in our report.

But, importantly, the results are the same. But it does stand to reason that—you know, not the percentage that have shown up, that have already gotten disability for diseases listed in Public Law 97-37 is representative of those 85,000. To date only a portion have even cared to walk in the doors of the VA. So, sir, I hope that does give you insight on the cost.

Mr. MOLINARI. It does. And may I make the suggestion, with the approval of the chairman, that as we wrestle with this legislation it would be helpful if those of you at the witness table or anybody out there can come up with additional information, more accurate information, perhaps, if that be possible, to enable us—I think you know you have a sympathetic committee here, we serve because we want to, and this is one area which I think we are all extremely sensitive to and we want to help. But we need help in order to help.

General FLYNN. Yes, sir.

Mr. MOLINARI. One item that came up from time to time which concerned me were hepatic disorders. You mentioned the fact that there are a number of ex-POW's who subsequently suffer from hepatic disorders and that a comparatively small intake of alochol could lead to cirrhosis and other liver diseases.

Is there anything being done to identify those having these hepatic disorders so that they could be told to limit, if not eliminate, the intake of alcohol because of its disastrous effects? I guess, Dr. Nardini, you're nodding your head, so I will ask you that question.

Dr. **Nardini**. Well, I don't think anything is being done. It would have to probably be done by the VA to have liver tests, which Dr. Woodward might talk about.

You see, what happened, I think, where I was in the main prison camp at Cabanatuan, where we had 6,000 men, we were losing 60 men a day during that 6- to 8-month or so period. What the men called yellow jaundice was extremely prevalent. Now, we had no means of studying what kind of liver disease or hepatic disease it represented, so we just guessed and called it yellow jaundice. But what it probably was, as Dr. Woodward might comment, was infectious hepatitis which was very, very widespread. I would say at least 50 percent of the total population of that camp, which means half of them, died—and half maybe subsequently survived—from the residue of that weakened condition of their livers, which would apply to what you said.

Somehow or another when the liver gets weakened, it has great reserve, but it does have an end point and it makes it much more sensitive to small amounts of alcohol. But no, the VA has not done any such checks. You would have no way of doing it on a non-VA basis. Whether it would show anything or not, I will leave to Dr. Woodward to answer.

Mr. **Molinari**. Dr. Woodward?

Dr. **Woodward**. The evolution of our knowledge of hepatitis, with viral hepatitis, began in 1940, and since then there has been an explosion of knowledge. Now, I would suspect that most prisoners of war had hepatitis, whether they knew it or not, because many did not develop this yellow color called jaundice. There are just as many who don't develop the yellow color as those who do.

My comment about the alcohol was simply to stress the point that someone who has damaged his or her liver then will find that it takes less of any liver poison to cause a greater effect. That was the analogy.

Now, the medical profession has a way of sifting out those patients who have lingering or continuing liver disease. As I indicated in my statement, many recovered. But when I spoke of the gray zone, I was speaking again about that person who may have been seemingly well through all of these intervening years and then he or she comes down with cirrhosis of the liver, and when you have cirrhosis you are more prone to develop cancer of the liver.

I only would like to stress—and I'm sure the Veterans' Administration would feel this way—that in that person, in sifting all of that information, that benefit of a doubt would go toward that person. But again, that's an area where sometimes you cannot pinpoint disease—unless you put a needle in the liver, called a liver biopsy, and we just don't do that at the drop of a hat.

Mr. **Molinari**. Let me just turn for one moment to Dr. Nardini. I must say, in looking at your testimony on page 4, where you include your own personal record, that it's incredible with the variety of illnesses that have beset you. You have run the course. I understand, and I hope you're wrong, from your testimony that you are suffering from cancer now and you have labeled it as terminal. You certainly don't appear that way. You were an excellent witness here today.

But looking at the variety of ailments that you have, do you have a family, brothers and sisters?

Dr. NARDINI. Not now.

Mr. MOLINARI. You don't.

Dr. NARDINI. Family, yes, but no brothers or sisters.

Mr. MOLINARI. Have any of the family members suffered from the same type of diseases, or could we exclude those, in fact, when you talk about tuberculosis, neuropathy, migraine headaches, coronary by-pass, cataract removal and now cancer of the postate?

Dr. NARDINI. No, no cancer ever in my family on any side, ever at any time. Maybe mild migraines, but not to the extent that it existed for me. No by-passes.

No, I think the history that you have there probably—but who can say—contributed to it.

Mr. MOLINARI. One of those gray areas that Dr. Woodward mentioned.

Dr. NARDINI. That's right. As Dr. Woodward said, you can't prove a lot of things. That's why we are somewhat handicapped and it is so much easier to apply a negative and say it isn't true, because you can't prove everything.

Mr. MOLINARI. You're a survivor in every sense of the word, Doctor, and I will put my money on you.

Just one last question, Mr. Chairman. I'm a new member of the committee, so forgive me if I ask a question that has been covered many times in the past—I am just wondering whether there have been epidemiological studies where you have taken this group of ex-POWs, particularly those in World War II in the Pacific theater, and compared them with a controlled group that may not have been in service, may not have been subjected to distress or to the severe malnutrition, as the pictures that we have here so graphically depict, in order to learn more by comparison as to the probability of the causal relationship.

Is there anything that you can point me in the right direction on?

Dr. NARDINI. Well, I don't have time to go into it, but the first studies after World War II were made very carefully, matched studies. In other words, let's say the southwest, a POW in the Philippines, a mate would be found for him of the same age, the same tactical operation and his duties, and the same period of time in the southwest Pacific area. These were matched and that's when these studies were first done. That's why that data comes out so sharp and clear in terms of deaths, suicides and so forth.

It is true that it did fade to some extent, but still, there continued over a period of at least 15 or 20 years to be showing, in these same matched groups, the ones who were studied. It is just like in the Canadian thing, where the brothers were out of the Pacific and the other brothers were out of the European theater, and ran a similar match. This was a matched group, too, but not quite as sharp as the other ones were in the American group.

Here we find even more whys. These whys have never, never been answered by the VA. As I say, the whys are just disregarded as any contribution to the issue that we have opened.

Mr. Molinari. Thank you very much.

Mr. Chairman, I have no further questions.

Yes, Dr. Woodward, did you want to add something?

Dr. Woodward. Just to followthrough. Even then, Mr. Molinari, that is a retrospective study, and there are pitfalls in retrospective studies, even though there are positive findings. God willing, we will never have a prospective study again to answer these questions. I have my own feeling that the study which we are waiting for is not going to solve this problem.

Mr. Molinari. That is why we need to examine this type of legislation; it may be the only way that you're going to get relief for something that we all feel very strongly is causally related to the illnesses.

Dr. Woodward. That was the substance of our presentation.

Mr. Molinari. I understand. Thank you very much.

Mr. Applegate. Thank you, Mr. Molinari.

Just let me say that I agree with Mr. Molinari, that certainly costs are a factor. We obviously have to consider costs as a factor in anything we do here. However, it should not be a dominant factor. If we in this committee and we in the Halls of Congress find that the disability was caused by the internment, then we will find the money.

[Applause.]

Mr. Applegate. Gentlemen, again thank you very, very much for appearing before us. It was very, very educational for me and, not knowing all of these things, being just a normal, everyday average person in the Halls of Congress sitting in a committee and listening to you experts, it is dazzling, it is fascinating, and I really appreciate your being here to add to this.

Thank you very much.

General Flynn. Mr. Chairman, on behalf of our committee and all those red jackets out there, and I guess on behalf of the VA because we do have an admiration for them and a brotherhood, we just want to thank you for this opportunity. I hope that will help the ex-POW's that are still living.

Mr. Applegate. Our next panel will be comprised of Mr. Joe Galloway, national commander of the American Ex-Prisoners of War, accompanied by Earl Derrington, the national legislative director, and Mr. Ed Jackfert, past national commander of the American Defenders of Bataan and Corregidor. They will be our next panel.

If I could, and if it would not be offensive to you, I would like to ask that we put into effect the 5-minute rule. I think much has already been said. We do want to hear you. We will take your statements and they will be made a part of the record.

Let me say two other things. First of all, the American Legion has asked that their resolution on POW's be entered into the record and, without objection, that will be included.

[The statement of the American Legion appears at p. 105.]

Mr. Applegate. Second, I would like to observe, too, that Mr. Hagan and his staff have sat through the entire proceedings up until this point. I appreciate the fact that you have stayed to listen. I appreciate that very much.

All right, Mr. Galloway, you're sitting in the center so I guess that makes you the leader. I am going to let you proceed. I don't want to cause any arguments between you three fellows so I will let you pick and choose as to how you want to start, and then you can proceed.

STATEMENT OF ALFRED P. GALLOWAY, NATIONAL COMMANDER, AMERICAN EX-PRISONERS OF WAR, ACCOMPANIED BY EARL DERRINGTON, NATIONAL LEGISLATIVE DIRECTOR

Mr. **Galloway**. Thank you, sir, for taking your valuable time to listen to our opinions, here, today.

Let me just say this, please. I would like to start off by asking you to back up your thoughts a bit. Last fall there was introduced for the American Ex-Prisoners of War organization a bill which became known as H.R. 6009. We supported H.R. 6009, even though we were aware that we did not have time to get it passed, but we thought we would try anyway. Some very interesting facts came out of that. No. 1, it is a bill which was introduced again this year, which, is now known as H.R. 864, in its exact entirety.

The Veterans' Administration stated at that time that if that bill was put in effect, it would cost $160-some million the first year. I'm not going to apologize for myself. I'm just going to say that I'm a layman, so to speak, at these hearings. But I would take the $160 million and I would say, "Well, now, we're talking somewhere in the neighborhood of 80,000 former prisoners of war, so if I divide $160 million by 80,000, I come out with a figure of about $2,000 apiece."

Then I look at some other statistics that have been put out by the Veterans' Administration which says that at the present time there are something like only about 32,000 former prisoners of war on the rolls for compensation. Out of that 32,000, 4,717 of those people, since the inception of Public Law 97-37, draw zero compensation moneys. They have service-connected disabilities, but they don't get paid.

The second line item that they have was the 10-percent line. They say there are 6,589 of those that have been given 10 percent. These are new or increased since October 1, 1981. That gives me a figure of about 11,000 that are drawing zero or 10-percent compensation.

The next major line item they had was 30 percent of 2,304. These figures take up most of the 15,962 that have been granted increases, either new or increased, since Public Law 97-37. Therefore, it tells me that at the present time 32,000 of our people are drawing compensation, and quite a bit of that is 10 percent. The Veterans' Administration would be hard pressed to prove H.R. 864 would cost $160 million. I think we're looking more at about one-fourth of that figure. That's my personal opinion, please.

One other statistic that was taken into consideration was the fact that the number of original awards since October 1, 1981, was 372. To me, sir, that just says that Public Law 97-37, while it did much for us, still in all, the Veterans' Administration only gave, brandnew compensation, to 372 people. That's not a heck of a lot of increases.

I, as the national commander, have crossed over this country doing what I feel I should do as national commander, and that is meeting ex-POW's. I have talked with many of them. I have been in their homes, and I have listened to what they have to say. Many of them tell me that they visited the Veterans' Administration hospital and in many places they got real good treatment, and in many cases not too good. Many of them took the protocol exam for which primarily the outcome was anxiety and depression. Seven thousand received ratings, and that was about it.

I would just like to draw this one conclusion, and that is the people that you see with us here today are the cream of the crop. We have swallowed our pride. We talked about our illnesses. We come here to appear before you to try to get a point across, and that is, that there is a group of people out there that need help.

I thank you gentlemen for your time.

[The statement of Alfred P. Galloway appears at p. 107.]

Mr. Applegate. Thank you very much, Mr. Galloway. That was a very beautiful expression.

Mr. Jackfert is a neighbor, not in my congressional district, but he lives closer to me than his own Congressman.

STATEMENT OF EDWARD JACKFERT, PAST NATIONAL COMMANDER, AMERICAN DEFENDERS OF BATAAN AND CORREGIDOR

Mr. Jackfert. Right, and I did go to you for help. I thank you very much for your assistance.

I was a prisoner of war for 3½ years. I was at Clarke Field when war broke out, and I ended up in Japan. As close as we can determine, there were probably 20,000 Americans in the Philippines when the war broke out. As you all know, when the war ended some time around April or May, especially in April, for some of the ones on the Bataan "Death March," there were about 11,000 who survived. Out of the Bataan "Death March," we lost about 2,330 Americans on that particular march.

Now, incidentally, at the close of the war in the Philippines the rations for a soldier was down to less than 1,000 calories per man. They needed at least 4,000 calories per man to survive in that particular type of weather and the work that they were doing. Subsequently, they lost a tremendous amount of weight. They were very, very sick. They had malaria, dysentery—you name it and they had it. And then they had to go on this march. Subsequently, as I said, we lost 2,330 on that particular march.

Today, about 40 years after we were freed from camp, as far as I can determine we have approximately 6,000 of us alive out of the 20,000. This is a 70-percent loss of our membership who were in the Philippines during World War II.

Now, these statistics further disclose that we have the highest mortality rate of all veterans' organizations in the United States. This is a fact. You have heard some of the reasons from the doctors before me as to why.

These veterans came back after World War II finished. Some of them stayed in the service, hoping that they would get adequate medical care by staying in the service. Others came out into civilian life and entered the mainstream of civilian life, taking jobs or going to school or whatever.

Very soon they began to have problems. These problems were the type that they thought resulted from the World War II experience. They went to the Veterans' Administration. For the most part they were rejected. They became frustrated. To this day, many of them still do not trust the Veterans' Administration and will not go back.

There have been many studies made on prisoners of war all over the world, noted people. The first one was the War Claims Commission. I want to read a question given to service physicans on that particular Claims Commission. They said,

> "Do you believe that the average American physician, because of the comparative variety of malnutrition here, would have difficulty in recognizing residuals of malnutrition for what they are?"

The unanimous reply was "yes".

Another question was asked:

> "Do you believe that because of the paucity of available knowledge on the long-term effects of malnutrition, and because of difficulty of diagnosis, that former POWs should receive the benefit of presumption of service-connection disability with the attendant privilege of entering a veterans hospital?

The physician respondents all answered "yes".

Another Pacific theater POW physician stated that:

> It is my opinion that virtually none of the released POWs of the Japanese, who underwent internment for three to three-and-a-half years escaped without some residual impairment of their health.

Yet another Pacific POW physician declared that,

> It is my opinion that no one who suffered the prolonged starvation, degradation, and physical suffering experienced by this group has been able to make full recovery, either physical or emotional. It is also my opinion that one who has not experienced such a condition has no concept of the problem presented by these men.

Then we go on down. Dean Nefzger in his study of 1970, and Gilbert Beebe in his study of 1975—we're talking about studies of POW's. Then we have a recent one by the NAS. Also, there are studies that have been made worldwide.

I would like to quote about the 1961 study that was made at the International Conference on the Later Effects of Imprisonment and Deportation held at The Hague. There were 70 participants from 12 countries, including 40 medical and legal experts. The conference reached several conclusions, summarized as follows:

No. 1: The Conference was of the opinion that there exist ailments and disabilities which appear long afterward among those who were interned or imprisoned in prison camps.

No. 2: These effects can become manifest at any time after liberation—not the day after, but any time—and no time limit can be set for their appearance.

This is just exactly what Dr. Woodward and Dr. Nardini was talking about.

In Entinger and Strom's study, they contend that to this day the former prisoners are vulnerable to all kinds of stress which can upset their equilibrium and result in a manifest illness.

Gentlemen, all this information is contained in the POW study prepared by the Veterans' Administration. It's a very, very good book. All this information is contained in it. They made a very thorough study of a the very people throughout the world that did this.

Now, of a more recent nature, I would like to quote from the Physician's Guide for Disability Evaluation Examinations published by the Department of Medicine and Surgery of the Veterans' Administration under the date of March 1, 1985. A part of chapter 17, Medical Evaluation of Former POW's, reads as follows:

> Studies in this country and abroad have shown that the physical deprivation and psychological stress endured as a captive have lifelong effects on subsequent health, social, and vocational adjustment. Specific residuals are known to be induced by prior malnutrition. Former POWs have significantly higher incidence rates for illnesses in many body systems and longer hospital stays. Vulnerability to psychological stress is also markedly increased.

Also of a more recent nature, we find that thousands of Ethiopians are currently suffering from malnutrition due to food shortages. Medical experts and scientists throughout the world are predicting that the residual effects of malnutrition suffered by this group will have long-lasting effects upon them.

There is only one other thing I want to bring up, Mr. Chairman. I want to refer to something that Dr. Cohn said. I want to read from their POW study of former prisoners of war. He is referring to a study made by Dr. Richardson.

> In 1964, a Government study of these field studies was commissioned and was conducted by Dr. H. J. Richardson. Richardson compared the health and social status of a sample of 100 Canadian Japanese POWs with a matched control group of their brothers who were not POW veterans. The study concluded that the former POWs were in a poorer condition—now, that's not what he said—than their brothers, who also had a wartime experience in social, economic and medical areas.

I want to thank you very much for your consideration and being able to speak here.

[Applause.]

[The statement of Edward Jackfert appears at p. 114.]

Mr. APPLEGATE. Thank you very much, Ed. It was very, very good information.

Mr. Derrington.

Mr. DERRINGTON. May I stand, sir?

Mr. APPLEGATE. Yes, you may, absolutely.

STATEMENT OF EARL DERRINGTON

Mr. DERRINGTON. Thank you, sir. I still have problems thinking while seated. Thoughts don't come to me unless I'm standing up.

Mr. Chairman and members of this most distinguished committee, and fellow POW's, we would like to thank you, Mr. Chairman, for the opportunity of coming here today and having you hear these most distinguished people, both from the VA and from the medical community here, and the POW Advisory Committee.

As time has gone by, and as I have observed the workings of this Congress and this committee for a number of years, I must go back to the origination of Public Law 97-37. I would like to personally again, as well as the POW community, thank you, Mr. Chairman, and Chairman Sonny Montgomery, for your wisdom in the original bill of Public Law 97-37. The wisdom of this committee then far overshadowed all of the concepts of the needs of the POW community at that time, and the wisdom of your committee's actions as time has gone by has proven you gentlemen to be great in your wisdom and service to the veterans of this country and, more particularly and specifically, to the POW veterans.

We would like to thank you and I personally would like to let the POW community thank you for this action that you have taken in these past years.

[Applause.]

Mr. **Derrington**. Sir, as we continue with this problem that we POW's have, it is a complex problem, and with the complex problem the position of the Veterans' Administration and their integrity, as well as the medical community and the doctors of the POW Advisory Committee, should not be challenged. There must be some way, workable way, for the two problems to come together and meet in such a way that the veteran that served this country and the POW's that served this country can be treated fairly. It is from this position, sir, that I appeal to you, Mr. Chairman, and your most illustrious committee, that you be the vehicle to solve our problem.

Thank you, sir.

[Applause.]

Mr. **Jackfert**. Congressman, may I say one other thing?

You know, this has been studied to death, it really has. They're talking about another study. By the time they complete this study—our average age is well over 65. Most of us could be dead and the VA wouldn't have any problems after that.

[Applause.]

Mr. **Applegate**. I want to thank you all very much. I want to thank Mr. Derrington for his very kind words, the compliments and the thanks, and I will express those thanks to the members of the subcommittee and members of the full committee and to Chairman Sonny Montgomery.

At this time I would recognize the gentleman from New York, Mr. Molinari.

Mr. **Molinari**. Mr. Chairman, I want to say we were very moved by the remarks that Mr. Derrington made about us, and we do, indeed, recognize the debt that this country has to those that served and were incarcerated in foreign prisoner-of-war camps. We want to do what we can to help. That is why many of us are on this commiteee. I felt we were both embarrassed, because we felt we should be standing up applauding you folks out there rather than us being applauded by you.

I just have one question, and I would like to get some indication from you gentlemen. We hear a lot about the POW hot line and that it might or might not be working well. Can you tell us, from your own experiences, from your membership and those that you represent, is it working, is it working well? Can we get an assessment from you as to that?

Mr. **Derrington**. Thank you, sir.

The POW hot line has been a tremendous success from the position of the Veterans' Administration I feel, as well as from the POW community. You must understand the personality of a former prisoner of war in order to really appreciate having a vehicle to communicate with someone who will get something done. As a whole, the people that have been answering the hot line have been very sensitive to the POW problems, and as the problems existed they go to the local areas.

Many times, as we have pockets of people that are informed on the POW problem in the VA community, we have other areas where they fail to see at the present time the life of the POW problem. They, shall we say, are still somewhat insensitive to the POW problem. Where they are responsive, it is tremendous. If you get a POW coordinator, a doctor, or an administrative POW coordinator, that still retains their insensitivity to the problems, the results of the POW hot line cannot be as effective. Yes, it is effective, and we appreciate it being used.

Mr. MOLINARI. Mr. Jackfert.

Mr. JACKFERT. Congressman, you ask why is there a need for a POW hotline. It is because out in the field the former POW who goes to the VA feels that he has not been treated correctly, or his problem has not been taken care of. So he tries to go to the hotline and call the attention to them, and I am sure that individual on that particular hotline will make that call back to the station that that veteran came from and there will be action taken. I am sure the hotline works very well.

Mr. MOLINARI. Thank you very much. I have no further questions, Mr. Chairman.

Mr. APPLEGATE. Thank you, Mr. Molinari.

I have one statement that I want to make and then I will call upon Al, OK?

Mr. GALLOWAY. Yes, sir.

Mr. APPLEGATE. I guess basically for either Mr. Galloway or Mr. Jackfert, in your statements you express the opinion that in individual cases the Veterans' Administration does not grant service connection where you firmly believe that they should make a favorable decision. The VA says they are granting service connection where circumstances reasonably support a conclusion that the disabilities were caused by service, OK?

Mr. GALLOWAY. Yes, sir.

Mr. APPLEGATE. If you could, we have discussed what we would like to do—you could offer some help—if you in the next few weeks, could keep your eyes open and do some investigating, let me have the names and the VA numbers of maybe about 20 or 30 cases, where you believe the VA did not make that correct decision. I have asked my staff to be available to go over very carefully each of these cases. We don't want to be deluged with a great number, but we want to have some, to pick out the best cases with the strongest evidence, where the VA has denied the claim. By doing this, I think the committee will be in a better position to judge whether or not the VA is indeed following their written policies on the POW's. I mean, it would help us, and we need that kind of input.

Mr. GALLOWAY. We will not have any problem in getting those cases for you, sir.

Mr. APPLEGATE. Good, fine. Thank you very much.

Did you have something else, Mr. Molinari?

Mr. MOLINARI. I just wanted to say for the record, Mr. Chairman, that I have been advised there are other members who, because of conflicts in schedule, could not be here today and who did want to submit questions for the record. I would like to make the request that the record be kept open for a reasonable period of time so that we can have those questions submitted by the members who are not here.

Mr. APPLEGATE. That will be done.

Mr. DEWEY (from the audience). Chairman Applegate, I would like to have one of my past commanders, who was in the ETO—for people who don't know what that means, it is the European Theater of Operations—to have a word in this hearing, as to the conditions there, from the air forces and ground forces.

I, myself, admit—unfortunately, I was only a prisoner of war for 4 months, captured in the Battle of the Bulge. I was a young fellow fighting for this country, for that American flag, and didn't expect anything from what I was doing except fighting for my country. I mean that.

I believed, through the acts of Congress, the Veterans' Administration was founded to primarily help the veterans. Am I correct, sir?

Mr. APPLEGATE. Absolutely.

Mr. DEWEY. Now, I have yet to see, when it comes down to the nitty-gritty of prisoners of war, how they have affected us. We knew—I think I will strike that from the record.

We knew who our enemy was—the Japanese, the Italians, and Germany. And I will strike that from the record. We knew who were fighting.

I went to a liberation ceremony at Liberty Park in New Jersey, where there were liberators. We went over there and I was a fighting combat soldier. I saw the enemy face to face. I turned out to be a liberatee instead of a liberator. That does eat on me a little bit. I think it does to all these people. We went over there not for conflict but to liberate, and we did that.

I would like to introduce my former commander, Jake McCauly.

Mr. MCCAULY (from the audience). I just want to be heard on the European Theater prisoners. All I know is there were 93,000 European prisoners returned at the end of World War II. Today there are 61,000. You don't have to be a mathematician to figure that out. The Japanese, we had 13,000 returned, we have 11,000 living today. To me, that is one-sixth. The prisoners of the ETO is one-third. We are dying twice as fast. And to be singled out—there were prison camps and there were prison camps. I happened to be in Stalag Group No. 4, the very first man in there. It was the only camp in Germany run by the Gestapo.

When Luft 6 was evacuated to our camp, when they came in, they couldn't believe that they were in a prison camp. Those fellows came down and thought they were in a country club until they saw our camp. They said this was a prison camp. Every man in that camp was under 100 pounds in 3 months, Stalag No. 4.

What I am trying to say is, at the end of World War II, the political realities were different then, than today. They knew even then, because we had "think tanks," that we needed Germany for an ally. Japan was destroyed.

But getting back to Europe, they put us in a camp that we called a "fat farm," Camp Lucky Strike. They barred all photographers, all newspapermen, including the Stars and Stripes, isolated us and put us together and we put on—they force fed us and we put on 2 pounds a day. They kept us over there for a month. We came back to the States.

I was discharged in October. I went to the Veterans' Administration 4 months later. They wanted to know where I got all the shrapnel at. I had no physical. Most of these fellows, they got no physicals at all. When they came back out of the prison camps, they were so glad to be home, it was like Utopia to them. Their little insignificant aches and pains they thought at the time were so minute because they were so glad to be able to walk around and eat some food and everything else.

I want consideration paid to the European Theater of Operations prisoners and check those things out that came right from this committee. We're dying twice as fast as the Japanese prisoners of war.

[Applause.]

Mr. APPLEGATE. Thank you very much for your statement. I appreciate that, and that will be in the record, too. It is a little unusual to take something from the audience, but it was important and I'm glad that you participated.

Gentlemen, thank you very, very much for being with us today. You have given us some real good background information, and if you can get those cases to us, we would appreciate that.

Thank you for a very good hearing.

[Whereupon, at 12 noon, the subcommittee was adjourned.]

APPENDIX

99TH CONGRESS
1ST SESSION

H. R. 864

To amend title 38, United States Code, to improve veterans' benefits for former prisoners of wars.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 31, 1985

Mr. APPLEGATE (by request) introduced the following bill; which was referred to the Committee on Veterans' Affairs

A BILL

To amend title 38, United States Code, to improve veterans' benefits for former prisoners of wars.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 312(b) of title 38, United States Code, is amended by striking out "or" at the end of clause (9) and by inserting after clause (10) the following new clauses:

"(11) chronic liver disease,

"(12) organic residuals of hypothermia,

"(13) gastro-intestinal disorders (including chronic diarrhea and dysentery, chronic colitis, and peptic and duodenal ulcers), "(14) arthritis,

"(15) cardiovascular conditions (including hypertension, arteriosclerotic heart disease, and cardiomyopathies),

"(16) peripheral neuropathy,

"(17) immunological dysfunctions, or

"(18) chronic pulmonary disease,".

(b) Section 612(b)(1)(G) of such title is amended by striking out "six months" and inserting in lieu thereof "30 days".

STATEMENT OF JOHN W. HAGAN, JR., DEPUTY CHIEF BENEFITS DIRECTOR, VETERANS ADMINISTRATION

Mr. Chairman and Members of the Subcommittee: I am pleased to be here this morning to present the views of the Veterans Administration on H.R. 864, 99th Congress, a bill which would amend title 38 of the United States Code to enlarge veterans'-benefits eligibility for former prisoners of war.

If enacted, this bill would add several medical conditions to the list of those for which service connection may be presumed if manifested to a compensable degree, at any time following service, by veterans who were prisoners of war at least thirty days. The additional conditions are chronic liver disease, organic residuals of hypothermia, gastro-intestinal disorders, arthritis, cardiovascular conditions, peripheral neuropathy, immunological dysfunctions, and chronic pulmonary disease. This bill would also reduce, from six months to thirty days, the period of time that a former prisoner of war would had to have been held captive to qualify for VA-furnished treatment for a dental condition or disability.

Mr. Chairman, we cannot support the enactment of H.R. 864.

At present there is no consensus within the scientific and medical communities regarding the long-term effects of the prisoner-of-war experience as it relates to the conditions listed in H.R. 864. Currently, certain scientific research is underway or being planned which will lend much-needed insight into this area. Of special note is a morbidity study of prisoners of war from World War II and the Korean Conflict which the National Academy of Sciences expects to complete sometime during 1986. Until that work is completed, it would be premature to expand the list of presumptive diseases because medical data now available do not show a likely relationship between the typical prisoner-of-war experience and the several conditions in question.

It is doubtful that research studies would furnish justification for the inclusion in section 312(b) of the broad categories of conditions now proposed under H.R. 864. Let me illustrate the point. The dietary deficiencies and other hardships which are typical of the POW experience might be found conducive to the development of, say, a particular liver disease; however, the phrase "chronic liver disease" is so nonspecific as to include numerous conditions more likely attributable to other periods of time and other causes. As for those conditions, the scientific studies will be of little help. Much the same can be said about the several other generic medical conditions included in the bill, such as gastrointestinal disorders, cardiovascular conditions, and chronic pulmonary disease. In short, we believe there must be a recognized nexus between a specific disease entity and the kinds of deprivations which are characteristic of prisoner-of-war internment before serious consideration is given to expanding the current statutory presumptions.

It is pertinent to add that the establishment of service connection on the basis of a presumption is not necessary and not resorted to where evidence indicates a disability has resulted from service. Special consideration is accorded to the unique hardships and privations endured by former POW's, and any reasonable doubt is always to be resolved in favor of the claimant.

We estimate that, if section 312(b) were amended in the manner proposed, first-year costs would exceed $167 million and five-year costs would exceed $766 million. (It should be noted that these estimates do not include costs for "immunological dysfunctions" or for any survivor benefits, because we lack valid data from which to compute them.)

We think the bill's proposed amendment to 38 U.S.C. § 612(b)(1)(G), relating to dental treatment for former prisoners of war, is likewise not medically justifiable. As a result of the passage of Pub. L. No. 96-22 in 1979, comprehensive outpatient dental care is available to former POW's who were interned at least six months. In the reported legislative history of that enactment, it was noted that the six-month requirement was established on the premise that nutritional deficiencies leading to dental diseases stem from prolonged periods of deprivation. We believe the current authoritative view is that, in a prisoner-of-war environment, dental pathology generally would not develop and become irreparable in less than six months' time. Of course, if dental problems result from traumatic injuries suffered during even brief internments, dental care is currently authorized on a service-connected basis. Thus, in our judgment, there presently is no sound medical basis for extending comprehensive dental care to all former POW's who were incarcerated between thirty days and six months.

Accordingly, the Veterans Administration opposes enactment of H.R. 864.

Mr. Chairman, that concludes my prepared testimony. I will be pleased to respond to any questions you or other members of the Subcommittee may have.

TESTIMONY OF LT. GEN. JOHN P. FLYNN, USAF (RET.)

PRELUDE

We have nothing except the highest regard for the leadership and corporate body of the VA. We now know them to be dedicated public servants—overworked and frustrated by austere budgets in the face of changing and increasing demands as its chief constituency, the World War II population, reaches its mid-sixties. We have had a few disagreements—they are honest ones and, hopefully, they too can be resolved. We appreciate their role—and do not envy it—and sincerely thank them for it.

I will limit my statements to those which represent the unanimous position of our Advisory Committee and, with minor exception, to those which have been publicly submitted to or discussed with the Veterans Adminstration, particularly in June of 1983 and April, 1985.

The Prisoner of War (POW) cohort is a small population of approximately 86,000, and represents only 3/10 of 1% of the total living war veterans population of 27,983,000 (1 Jan 85). It has a unique profile, characterized by the after-effects of their experience and an identified higher morbidity and mortality rate, differing by location and length of captivity and the nature of the treatment received from their captors.

The vast majority of the survivors (95% or 81,347) are World War II prisoners. Of this World War II group, 66,532 are from the European and Mediterranean Theatres and 10,255 are from the Pacific Theatre (a ratio of approximately six to one). The balance of less than 5% is from Korea (3,618) and Viet Nam (620). In the last six years, 14% (12,180) of the total have died.

A segment of this population has sustained trauma perhaps second only to the paraplegics, amputees and serious burn victims; but, unlike them, the wounds are often not so visible. It is in their minds and internal organs and skeletal structure. Its effects are latent in their manifestation, debilitating and life shortening, medically identifiable and supportable, but too often officially unrewardable by present law.

The Congress took one laudible step in PL 97-37 (effective October, 1981) which recognized nine diseases by law as service-connected diseases of captivity. It took another, when in PL 98-233 (effective 1 October 1983) it added Depressive Neurosis as a presumptive disease. The Advisory Committee believes that passage of PL 864 would finally solve the Ex-POW's problem because *with proper qualification* it would be a just solution to that problem.

THE ANATOMY OF THE PROBLEMS WITHIN THE VA

The vast majority of the World War II prisoners had no medical records while in prison and perfunctory, or in some cases, no medical examination upon release from service after the war ended. The long-term and latent impact on their health was not to be recognized until the seventies, three decades after their release. It is not always acknowledged today, despite the growth of that body of medical knowledge. Because of this profile, it is difficult for the VA to tailor and maintain programs for this small, special population. Some hospitals may serve as few as one or two Ex-POWs while others administer to 500 to 1,000.

Understanding of the system as it specifically relates to the Ex-POW issue requires a degree of familiarity with the VA and how it operates. It has three major components: The Department of Medicine and Surgery, The Department of Veterans Affairs, and the Board of Veteran Appeals. All three report to the Administrator directly, their action monitored by his relatively small staff.

The three components, while synergistic and serially supportive, maintain a legalistic separation by functions and design, each holding a distinctly defined role.

Department of Medicine and Surgery (DMS)

The DMS role, beyond health care, is to examine the patient and to record the medical profile of the Ex-POW—the first step leading toward individual judgment of disability and subsequent award of disability.

This requires privileged doctors who are sensitized and knowledgeable of the after-effects of imprisonment, special protocols for the examination to record the Ex-POW's current health status, and continued education of the VA field. The latter is a formidable task compounded by the fact that some examiners remain unfamiliar with the subject, to especially include fee-based or emigre doctors, young professionals of various skill levels, etc.

Understanding the health problems, the special nature of the POWs' history is paramount. If the examiners are lacking in knowledge or are indifferent to the Ex-POW populations, then the POW is unjustly penalized when submitting claims for disability. The adjudication system is critically dependent upon the doctor's written identification and description of the diseases since the DMS is normally and deliberately separated from the adjudication process. This is done in order to maintain the integrity of that system. The DMS, by directive, has identified "senior coordinating physicians" who are required to render opinions concerning the possible relationship of the Ex-POWs' symptoms to the prison experience. This has been only partially effective to date.

Department of Veterans Benefits (DVB)

The DVB maintains a careful legalistic separation from DMS and has had a heavy involvement in structuring the program for Ex-POWs. Their statistics as of December 1, 1984, indicated an impressive 39% increase in disability awards.

Of significant interest, from October 1, 1981, to December 1, 1984, a total of 12,325 disability awards have been made. Of these awards, approximately one-half were awarded for psychiatric disorders. Of these roughly 6,000 cases, the majority was granted an award of 10% (see Tab A). Our conclusion is that PL 98-233 (2 March 1984) which identified dysthymic disorders as a compensable disease is a significant contributor to this increased and improvement in statistics (see Tabs A and B), and not necessarily PL 97-37. Also, in the period from 1 June 1984 to 1 December 1984 slightly more Ex-POWs died than were awarded disability during that timeframe. This trend is likely to continue.

Note: We have requested a one-time report to indicate the number of Ex-POWs receiving disability ratings for the first time. Also, we requested the number of Ex-POWs who submitted for, but were denied disability ratings.

Board of Veterans Appeals (BVA)

The BVA is also legalistic and makes its judgments as a separate reviewing authority. Of necessity, in its consideration of the case it reviews the substance and reasons for the decision by DVB.

Both the DVB and BVA are properly and historically oriented toward the veteran but against granting liberal interpretations in order to protect against fraudulent claims. This serves their charge and, thus, the public interest. See tab C.

The BVA approval record is disappointing. To date, only an exceedingly small number of the total submissions have been granted. At one time the review time was over 400 days, but since then it has been reduced to a commendable less than thirty days.

The problem is that no matter the empathy, the prodigious effort, it is difficult to intrude into this legal system a small, special population, a number of which manifestly suffer from after-effects of prolonged malnutrition and physical trauma, but relief is not permissible under the current laws. While this maintains the integrity of the system for the majority of claims and protects it from violations, as it now exists, its result is injustice to the small number of Ex-POW veterans, less than 3/10 of 1% of the total veteran population.

KEY ISSUES

Of the 21 recommendations listed in the Advisory Committee's June, 1983, report to the Administrator for his endorsement to the Congress, the VA and the Advisory Committee were in complete concurrence on all but one.

Extract—June 1983 report to the advisory committee

Committee's recommendation #1

That the VA should accept as sufficient evidence of service-connection the findings of epidemiological studies of former POWs and the medical literature on conditions prevalent among former POWs. We strongly believe that the evidence available is more than sufficient for a finding of reasonable doubt in favor of the former POW.

VA comment

The VA will grant service-connection for any disease or disability when the medical and scientific communities reach a consensus on a study which is statistically significant, has withstood peer review, and can be duplicated, and which finds that there is a relationship between the POW and the disease or disability. Resolution of reasonable doubt is applicable to individual fact situations.

Committee's response on VA comment

"We reserved on the VA's comment to our recommendation. The sense of PL 97-37 was to shift the burden of proof from the Ex-POW to the government in certain categories where statistically significant evidence exists that service-connection is likely or probable."

"We support the VA's position that the integrity of the system must be upheld and guarded against specious or fraudulent claims. However, we also believe that the integrity of the system must also encompass the principles of justice and fairness to all categories of veterans. In this connection, we note that precedence exists within VA policy for this recommendation, e.g., the VA's recognition of the ancillary results of amputation and its relationship to cardiovascular problems in that segment of the veteran's population.". . .

The committee's current comment

The Committee believes at the present rate of progress it is most difficult, if not impossible, to overcome the VA's stated requirement before most of the affected population dies. The statement itself is an amorphous one. The reason for this is the majority of the medical community has never been exposed, in-depth, to the unique and latent after-effects or prolonged exposure to malnutrition, stress, and other associated effects on incarceration. In fact, that is a central problem. Yet a significant number of studies, professional papers both here and overseas, identify the medical characteristics as an aftermath of imprisonment in a prolonged harsh and brutal environment. There is a number of distinguished physicians and medical researchers that are knowledgeable of these syndromes and a significant number of medical studies which address this problem. Many of these studies emanated from Europe as a result of World War II. The precursor conclusions were made by a Scandinavian group that studied the long-term effects upon Jewish survivors of the Nazi death camps.

Some World War II nations faced with problems similar to those encountered by us recognized in principle the debilitating and latent after-effects as a result of harsh imprisonment by changing the law to automatically compensate those who were held in World War II.

Although the committee did not comment at that time, it also had a reservation on the last sentence of the VA Comment on the second of the committee's recommendations. (See below.)

Committee's recommendation #2

That former POWs who have been demonstrably exposed to excessive and prolonged stress and deprivation should be presumed service-connected for the following diagnosed conditions: (1) psychological-psychiatric disabilities; (2) muscular-skeletal disabilities; (3) "psychosomatic" disorders such as gastrointestinal complaints, peptic ulcer, and chronic colitis; (4) alcoholism and its associated diseases; (5) immunological dysfunctions, for example, certain allergies, autoimmune disease, possibly neoplastic disease, and increased susceptibility to tuberculosis; and (6) cardiovascular conditions, such as hyptertension, arteriosclerotic heart disease, and cardiomyopathies.

VA comment

We concur if the intent is to expand the number of candidate disease entities that are legitimately identified as possible risks for former POWs and the sense of the recommendation is to increase the likelihood of detection in examination.

If, on the other hand, the intent is to give a blanket systemic presumption, we do not support the recommendation.

Committee's current comment

The committee also opposes the concept of blanket systemic presumptions. It is one of the reasons why we propose that in HR-864 the Ex-POW must meet the two tests of: (1) imprisonment in locations of extremely harsh circumstances, and (2) they must have the symptoms of residuals of identified listed diseases.

POSITIONS ON HR. 864

After more than three years of considerable effort and professional association with the VA, the Advisory Committee has concluded that the Ex-POW population is not receiving deserved compensation because of constraints under current law. Further, this situation will continue unless legislation relief is granted. Thus, the committees believe there remains significant injustice in the system and it fully supports the passage of HR-864 in principle, but would recommend certain refinements when it is addressed by Congress.

We fully endorse those listed diseases in HR-864 as latent residuals characteristic of imprisonment under prolonged and harsh circumstances; however the Advisory Committee's report of April 22, 1985, recommended to the Administrator of the VA two qualifying conditions for eligibility should be imposed. An expanded version is as follows:

First.—Location is known as one where conditions of captivity were manifestly harsh and characterized by such things as physical violence, torture, executions, enforced hard labor, prolonged isolation, malnutrition, or starvation, stress, transport by inhumane means such as "Hell Ships," sealed box cars, or brutally forced marches with insufficient food in extreme weather conditions, e.g., Philippines, Japan.

Second.—The symptoms or after-effects of the diseases listed are evident in the Ex-POW patient by medical records or by current medical examinations.

If these two conditions are met, then the applicant is not required to provide previous medical records and claims could not be disallowed for that reason.

AFFECTED POPULATION

Our estimate (shown below) of the population of 86,000 Ex-POWs alive on 1 January 1985 and passing the first of these two tests is roughly one-third (25,000) of the would-be candidates to receive service-connected disability by virtue of location. This estimate is obviously sensitive to its assumptions. Also, a good number of this population will be eliminated since they did not show symptoms of the second test (evidence of the diseases). Also, of 86,000 Ex-POWs still living, some 32,000 are already receiving compensation and face a higher mortality rate than non-POW veterans. It is reasonable to state this trend can only continue as the World War II population is in their mid-sixties with a death rate that is rapidly increasing.

Estimate of ex-POW population eligible and surviving test one

Only a portion of the 1 January 1985 Ex-POW population will survive the first test—that of imprisonment in locations where treatment was exceptionally harsh and manifestly evident. A rough assessment of the number that would be follows:

1. WWII, Far East Living Captives, 10,255; Korea, Far East Living Captives, 3,618; Viet Nam, Far East Living Captives, 620; Total, 14,493.

Assume 80% are eligible under Condition 1—11,594 would survive Test 1.

2. WWII, European & Mediterrean Theatre Living Captives, 66,532.

Assume 20% are eligible under Condition 1—13,306 would survive Test 1.

Grand total: POWs from all theatres now eligible under Condition 1 but must still pass Condition 2, 24,900.

Note: Assumes: 1. All Ex-POWs will apply—this historically is not true by desire or by lack of knowledge. 2. Does not count those already receiving a high percentage of disability.

COST OF PRESENT PROGRAM

It is difficult for the VA to break out the costs of the present POW program because its automated data system dates in the sixties and the small size of the Ex-POW population. Efforts to update their system are currently underway. It is also hampered by the size of its senior supervisory staff in the face of increasing demands as the decreasing World War II population ages and the Viet Nam needs emerge and as budget pressure increases.

At this juncture, we opine that PL 97-37 did not incur predicted costs because of the following:

(1) From a Health Care standpoint, the Ex-POWs were awarded a priority second only to 50% service-connected veterans. Thus, the POWs were moved ahead of the less than 50% service-connected and nonservice-connected veterans.

(2) From an adjudication standpoint, it required sensitization training for the staffs, publication of directives and a number of field trips.

(3) From an appellate standpoint, it required sensitization training and extended the length of time for processing of appeals.

(4) The increased awards were significantly offset by deaths; some new increases were as a result of PL 98-233 which added Depressive Neurosis to the list of presumptive diseases.

(5) Of the 12,370 favorable ratings and reratings, 28% were at a 0% level and 43% were at the 10% level for a total of 71%. An additional 19% were rated or rerated at 30%. Only 1 out of 10 were rated above 30%. This data also includes 6,000 psychiatric disorders rated because of the presumptive provisions.

In sum, we think that it chiefly required reallocating priorities and efforts, sensitization training, reorientation of personnel and priorities. This does not say that it wasn't a burden on an already over-burdened system, nor that it had no impact on that system or the budget of the VA. What it does say is that the impact is probably felt chiefly in the nonservice-connected sector for reasons of their lower priorities. In this connection, we suggest simplification of the award of disability for Ex-POWs might reduce somewhat its vexing load on the adjudication and appeal process and result in very modest but favorable offsets through improved efficiencies such as shortening the time from initiation of a claim to adjudication and appeal. More important, it would result in justice to the Ex-POW claimant.

COMMITTEE'S SUGGESTED COST CONSIDERATIONS FOR H.R. 864 AND OTHER FUTURE PROGRAMS

We recommend that the following mitigating factors also be taken into consideration in preparation of cost estimates for HR 864:

(1) Only a portion of Ex-POWs will qualify on the basis of location and symptoms.

(2) Of those, a number will not come into the system by individual choice.

(3) A number are already receiving compensation.

(4) Mortality rates be used and be adjusted to the higher rates of that for an Ex-POW.

(5) Estimates of offsets be considered, such as reduction of workloads in the adjudication and appellate processes that provide for more timely judgments and greater efficiencies.

THE RESULT

The problem has been "studied" almost literally to death.

The basic issue is justice, and the Ex-POW community is simply asking for justice. The majority of Ex-POWs have never shown up in the system nor do they have symptoms of the residuals. But those who do—the minority—those that have displayed symptoms that are identifiable as being related to the prison experience, and the locations and conditions within the prison or camp in which they were held is well-known, are still being excluded from recompence for their long-term travail with its subsequent loss of earning powers and shortened life span.

Note: There is little comfort in review of the length of time taken for post NHS studies conducted on POWs. A morbidity study based on data from 1965 to 1967 was finished in September 1975, almost 10 years ago. Of two mortality studies: the first was based on data up to 1965 and was finished in June 1969, the second based on data up to 1975 was finished in 1979, 6 years ago.

As they approach their last years they would have due compensation and at least their families would have a modicum of dignity and security consistent with their sacrifices and travail. The Ex-POWs expect justice and understanding. They appreciate compassion and hope for circumstances that are commensurate with their individual sacrifices—sacrifices that assisted this nation and other nations to survive their freedom in a world where that freedom depended upon the behavior and valor of our men in battle.

If it is the cost of such a program that is underwriting this stance, then we recommend that other programs of lessor priority be examined in order to provide priority relief to those who are the survivors of the long-term victims of one of the most difficult of all tasks in battle—captivity. This is quite often a result of the judgments of their commanders. The men of Bataan and Corregidor had no choice in their circumstances any more than a man who has bailed out of his disabled aircraft had choices, or an infantryman encircles by superior forces and out of ammunition had a choice when they have lost the ability, either by an order from their commander or by circumstances, to continue to fight.

The Ex-POWs number amongst the men who have been on the leading edge of protecting our society and that of a free world. They were committed to their fate by fate. Their conditions are known as a matter of fact. Their performance, their integrity, their courage were commendable and befitting of the image of U.S. fighting men. These men have never let their nation down, and the nation should never let them down, but that is the result of what we are doing now. HR 864, if passed, can provide the long overdue relief from injustice.

We have no doubt how this nation would vote, if given the facts, on this issue. We believe they would opt for an acknowledgement of service-connection of related residual diseases based upon the severity, the length and location of imprisonment. We believe the nation would opt for justice and subsequent recompense to the individuals who underwent the circumstances and display residual diseases that cannot be ruled out and are the likely result of such experiences. This nation would do this because they believe in justice. It knows that a free society that does not have justice cannot endure long on expedient judgments that violate the principles upon which our society was formed.

The Ex-POW leaders come to you because they believe in justice and they know the conditions under which most of their constituents live. They are the leaders of this community and are intimately familiar with their circumstances and needs. They spend a great deal of their time and personal income to right what they consider to be an injustice.

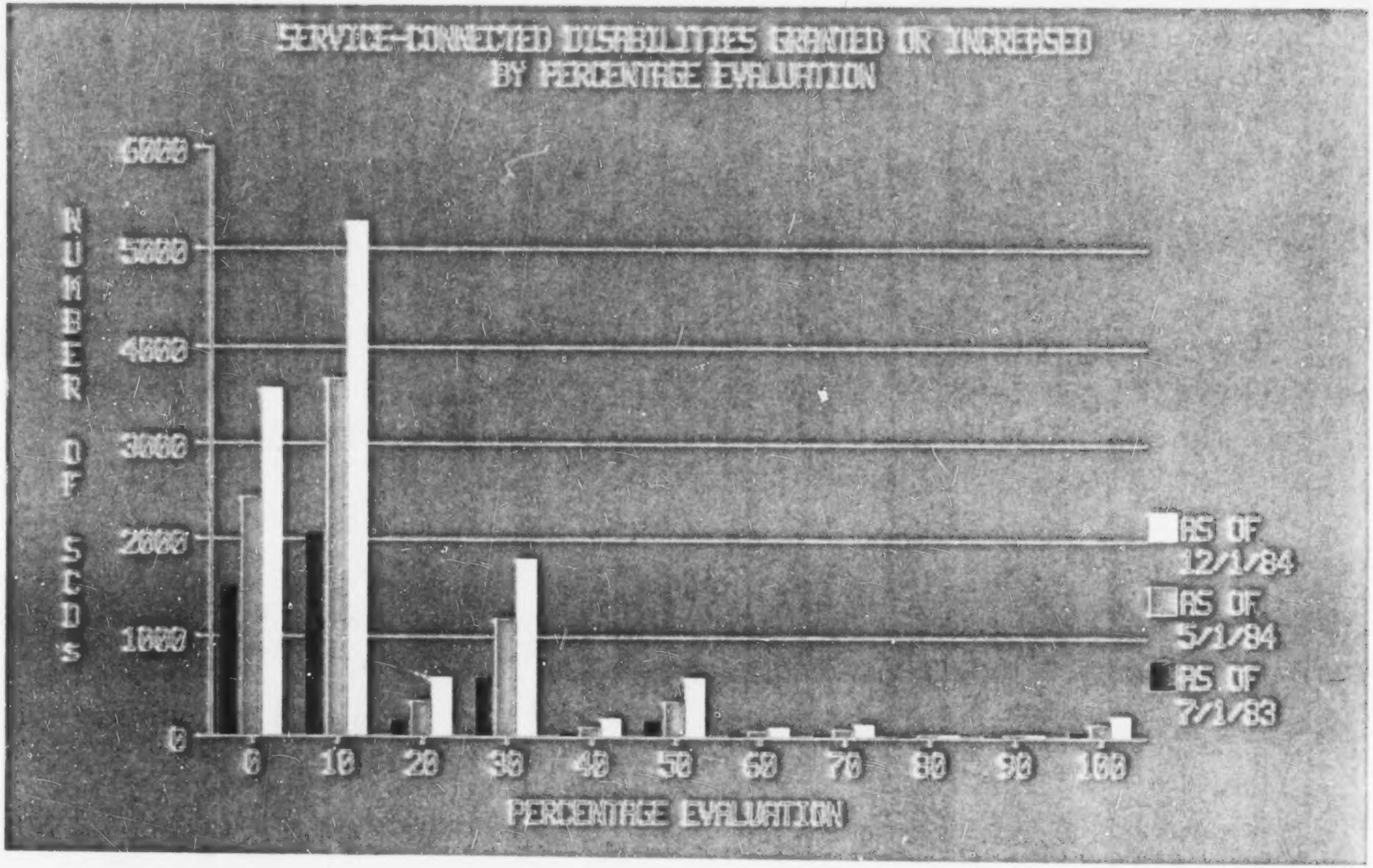
Our medical sub-committee, which is comprised of distinguished medical doctors, selected by the VA and drawn from the various fields, are knowledgeable of the after-effects of prolonged imprisonment. Many of these men have been associated with the program for a number of years. The medical side of our committee was purposely selected because of their medical knowledge in related disciplines, to include past and recent understanding of the residuals of prolonged and harsh environments.

The majority of the administrative committee is drawn from Ex-POWs, most of whom are from World War II and have been National Commanders of Veterans Organizations. Thus, they have been involved with dealing with Ex-POWs and are sensitive to the signals they can discern in most of their constituencies.

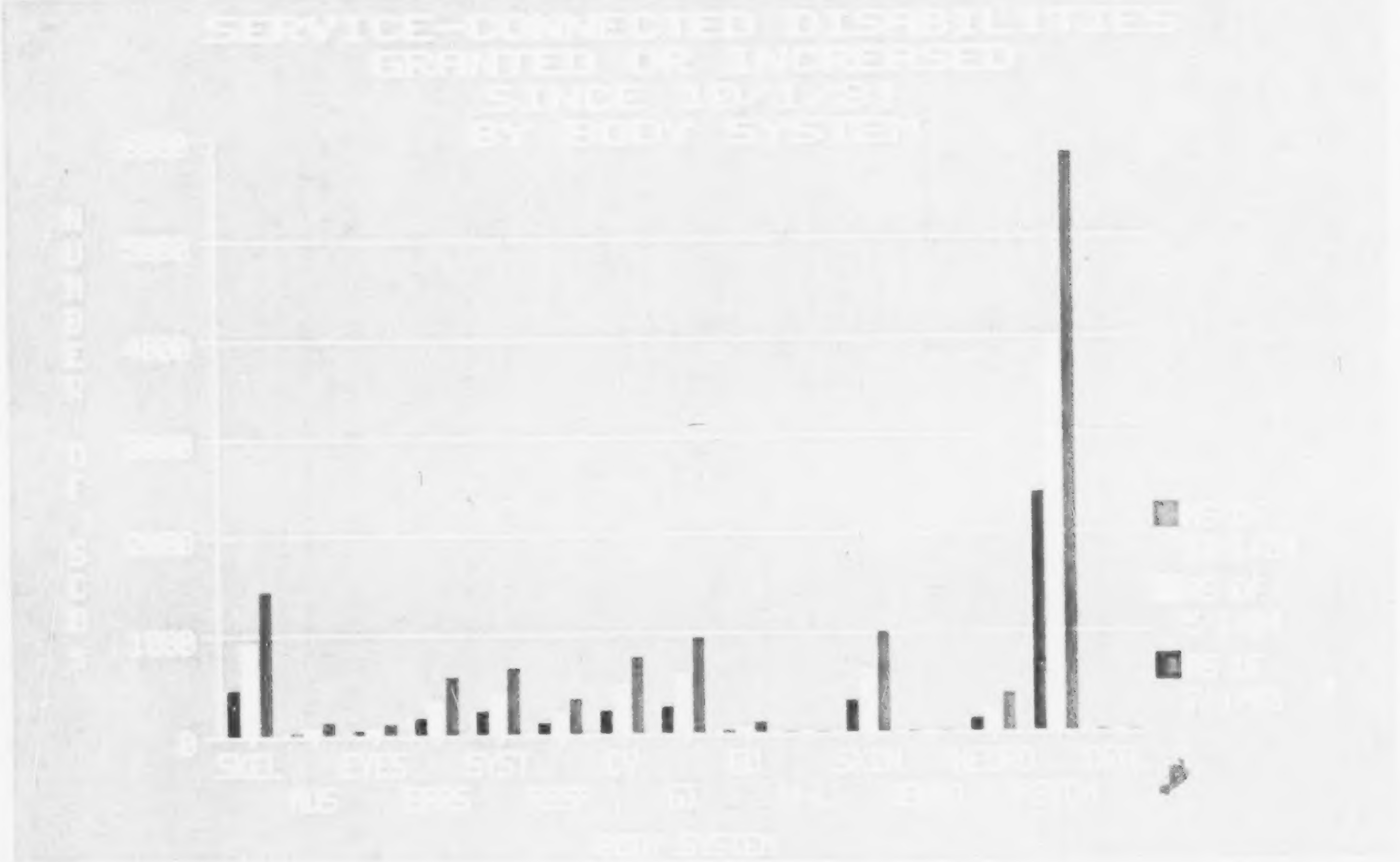
This Committee has been involved formerly in an advisory role to the VA for more than three years. In some instances, the project has consumed their interests and efforts during those years and they have individually applied themselves diligently to this project. The Committee offers a plethora of informed medical information and a significant amount of evidence that supports their professional conclusions—judgments that are supported by a number of professionals in the VA field.

Finally, let it be clear to all that the Ex-POWs are not asking for their "piece of the pie." They have been understandably puzzled, confused, and somewhat outraged by the insouciance attended to their circumstances. A good number are bitter and disillusioned and have dropped out of the system, but a majority have faith in the system—the system like many other systems which they so stoutly defended on past battlefields for great causes. These men and women have known the bitter realities within the societies against which they contended. They appreciate and understand and are proud that they assisted our nation. They will never understand the unrealities of today's judgments, which seem to turn their backs on those who have helped it to survive. Only Congressional intervention can once again revive their faith and trust.

TAB "A"


SERVICE-CONNECTED DISABILITIES GRANTED OR INCREASED
BY PERCENTAGE EVALUATION
NUMBER OF SCDs
6000
5000
4000
3000
2000
1000
0
0
10
20
30
40
50
60
70
80
90
100
PERCENTAGE EVALUATION
AS OF 12/1/84
AS OF 5/1/84
AS OF 7/1/83

TAB "B"


SERVICE-CONNECTED DISABILITIES
GRANTED OR INCREASED
SINCE 10/1/91
BY BODY SYSTEM

h. *Title 38, USC, Sec. 313:* The Committee is seriously concerned with the failure of the rating boards, adjudicators, and the BVA to adhere to Section 313 (b) of Title 38, USC, i.e.: "Nothing in section 312 of this title or subsection shall be construed to prevent the granting of service connection for any disease or disorder otherwise shown by *sound judgment* to have been incurred in or aggravated by active military, naval or air service." In almost every case denied by the aforementioned entities, there was no reference to or evidence that this particular section was given any credence. Throughout the deliberations of this Committee, the fact that the Ex-POW is a "special" category veteran has been emphasized. Yet, when we review the high number of denied claims, there is no evidence that such has been the case.

Prepared Statement of John E. Nardini, M.D.

To: Members of the Subcommittee on Compensation, Pension and Insurance.

May I express appreciation for being provided the opportunity of addressing this committee on this important and urgent issue of consideration of compensation for illness of diseases incurred during prolonged prisoner of war conditions.

I am John E. Nardini, M.D., Captain, U.S. Navy, Retired, in active private practice of psychiatry and neurology in Washington, D.C. I have been in continuous practice for 47 years—23 as a regular Navy Medical Officer retiring with rank of Captain and 24 years in private practice in Washington, D.C.

On April 9, 1942 while serving as Battalion Surgeon with the U.S. 4th Marine Regiment on Bataan, Philippine Islands, I was captured by the Japanese Imperial Army and held as a prisoner of war for three and a half years to the end of World War II. During that period of time I functioned as a medical officer for my fellow POWs and observed and worked in the midst of universal sickness, deprivation, misery and widespread death.

I wish to fully support and speak in favor of H.R. 864, which represents a long overdue correction of failure of needful help to a small but significant now aging group of former POWs. It should be emphasized that this group is asking for nothing more than the law provides and to which they are entitled.

The issue has always been a wide chasm that has existed between the established rigid, hide bound, conservative, "scientific," over-cautious approach in medicine plus in this case the medically entrenched monolithic, highly defended bureaucratically, obsessively legalistic Veterans Administration Organization on the one hand, and on the other hand the heavy weight of national and international medical evidence that the POW experience has had and still has a major contribution to serious past and current physical and psychological illness in their group of survivors.

What gains have been made in the past for the POW have been through the advent of Congress which has not been bound by the rigid restraints of legalistic quibbling but could come directly to the point of recognizing past injustices, fair needs of deserving groups and be in position to decere benefit of doubt which seems to have been anathema to the bureaucracies and therefore not applied whenever possible.

There is not sufficient time here to describe in full the picture of POW life and I have therefore appended a number of papers I have prepared in the past to this presentation. However it is necessary here to relate the essence of the conditions that relate to the nature of the current bill.

The group of men involved in the present circumstances are surviving POWs from World War II Pacific and European theaters, Korean War, and Viet Nam with ages 65 and less. Periods of imprisonment range up to eight years. The South Pacific World War II group was the largest and most physically traumatized with close to four years imprisonment. And the longest in confinement was in Viet Nam. The World War II South Pacific was the Bataan-Corregidor Death March Group of 30,000 Americans and 60,000 Filipinos. The death rate was 40–50% over the three and a half years. The highest death rate of any overall large combat group in World War II was the submarine service with 22%.

My role was that of a physician in the midst of the entire POW experience in the Southwest Pacific in World War II as a prisoner of the Japanese Imperial Army.

It may need to be recalled that the wide scale sudden attack by the Japanese in World War II caught the U.S. among others by surprise. In the Philippine Islands this resulted in insufficient food and medical supplies along with others from the start. Thus the troops went on less than one half ration six days after the war started 14 December 1941. As the war on Bataan continued men were on starvation rations, lost weight rapidly, had chronic dysentery, recurrent malaria due to lack of medicine and even before capture some vitamin and nutritional diseases such as Beri-Beri and Pellagra. After capture conditions were worse. There were forced marches, summary brutal beatings, starvation and executions. In prison camps at O'Donnell and Cabanatuan absence of sanitation, lack of water and food, no medication, further abuse and some killings continued to swell the death rate. During the first 5 to 6 months after capture I had a Bamboo Shack of 100 men and was losing 2 to 4 men per day from a combination of lack of food, no medications, chronic dysentery, malaria and the vitamin deficiency diseases of Beri-Beri, Pellagra, and Scurvy. All men were sick and suffering. The Japanese at this time had American Red Cross medication and food but would not release it. The overall death rate in the camp at Cabanatuan, P.I. was 60 per day in a 6,000 population. Hope was at a low ebb. Eventually some improvement occurred. I too experienced all of the above but did work through it all. I suffered from malaria, dysentery, beri-beri, pellagra, kidney stones, nutritional edema, weight loss to 80 pounds and tuberculosis. On the psychological side was continued intimidation, beatings, threats, word of murder and even massacres for example on Palawan, P.I. Numerous unmarked ships transporting POWs away from the Philippine Islands were damaged by our advancing forces with much misery and death. For example 390 survived out of 1,600 in December 1944 on the Oryoko Maru and four survivors out of 1,800 on another ship.

The physical and psychological impact on this group of men and the survivors will equal any hellish experience to which men have been put. The recognition and acceptance of this trauma has been dismally remote and not fairly applied to the obvious mental and physical sequellae.

For years now I have followed many men in the aftermath of the POW years of the Philippines, Japan, Manchuria, Korea, and Viet Nam. Many have made what would seem to be satisfactory adjustments. All have done so at great cost in peace of mind, some limitation of accomplishments, inner stress and tension, difficulties and periodic depressions. The general death rate is ahead of their matched non-POW group. My own past POW medical record included Pulmonary Tuberculosis, peripheral neuropathy, severe recurring migraine for 20 years, quadruple coronary artery by-pass, cataract removal with implant and a 7-year losing battle with cancer of the prostate with bone metastasis to current terminal state. As an aside the VA has never been a part of my medical support system.

I have over the past 40 years because of my experience and positions been called back into medical matters pertaining to POWs. The most recent one has been to serve as a member of the Advisory Committee on Former Prisoners of War to the Administrator of the Veterans Administration. In addition to myself there have been five other physicians with special medical credentials appointed to the committee by the VA to advise on medical matters. All physicians have read the literature extensively and discussed extensively together the probable sequellae to such a prolonged exposed state of stress, deprivation and disease and conclude that there is clearly a major contribution to the early onset of many of the diseases to which men might readily develop and other specifically related to the unique experience itself. In relation to item (1) chronic liver disease it has not been described except in passing of the extensive outbreaks of "yellow jaundice" in the prison camp at Cabanatuan, P.I. This was most certainly a contagious hepatitis that contributed to the general malignity and higher death rate and very possibly some of the later liver cancer deaths. Secondarily, these "yellow jaundice" cases may have so weakened the liver that later small doses of alcohol may have rendered the liver subject to easy or early cirrhosis. The severe and prolonged actual and later stress factors make it easy to see how some men with the proclivity fell easy prey to over use of alcohol.

All men at various times were subject to cold with freezing effect to the extremities either at work or after work (11). Some men with symptoms of peripheral neuritis in the feet due to beri-beri felt a great sense of burning or "electric feet" and would soak them in cold water only to experience worse discomfort later. In a few cases the Japanese doctors misdiagnosed the picture and performed needless damaging and crippling defects by performing some lumbar sympathectomy operations.

In regard to (13) little need be said as all men were subject to poor, erratic, ill prepared, poor variety food with chronic dysentery for all the years of imprisonment. (14) Arthritis also not significantly present except as related to specific events or conditions of employment like work in copper mines and specific injuries, or work in the holds of ships. However arthritis is often considered a stress related disorder and in this connection should be so considered in this group. (15) The POW experience placed a disproportionate load on heart function by forcing the men into often difficult cardiovascular demands on marches, work requirements that were greater then their bodies could manage on the insufficient amount of food and the poor physical shape they were in. Beri-Beri is known to produce permanent cardiovascular damage which could certainly produce fertile soil for later cardiomyopathies. (16) Neuropathies of the eyes are easily determined and no problem of detection as the findings are clearly objective and the cause usually accepted without reservation. The leg myopathies although more numerous are not as critical as the eyes therefore perhaps complained of less. The incidence is high (17). Immunological dysfunctions or (18) chronic pulmonary disease is covered well in Dr. Woodward's discourse. Special attention should be paid to Dr. Woodward's thorough and specific discourse on the stress factors in diseases and the aftermath effects of disease process.

Let me again express my appreciation of the opportunity of addressing your committee and I will be happy to answer any further questions you may have.

DISCUSSION

The following discussion is presented for the reasons stated in the opening letter.

The specific issue at hand is the recommendation at our 1983 report of the Advisory Committee on Former Prisoners of War that reads as follows: "There is ample evidence in the published literature with statistical evidence to support the concept that extremes of physical and mental stress and deprivation contribute to death, shortened life, increased incidence of disease, and a lessened quality of life. We believe that ample evidence exists as to the probability of current disabilities experienced by former POWs being caused by their service. Within the VA doctrine of Reasonable Doubt, we are of the opinion that presumption of causality should be extended for former POWs who have been demonstrably exposed to excessive and prolonged stress and deprivation to include conditions that fall in the following listed categories: (1) psychological-psychiatric disabilities; (2) muscular-skeletal disabilities; (3) "psychosomatic" disorders such as gastrointestinal complaints, peptic ulcer and chronic colitis; (4) alcoholism and its associated diseases; (5) immunological dysfunctions, for example certain infections such as tuberculosis, allergies, autoimmune disease, and possibly neoplastic disease; and (6) cardiovascular conditions such as vascular hypertension, arteriosclerotic heart disease, and cardiomyopathies."

The VA position is that they cannot defend the probable causes of disability of POWs as recommended by our committee.

There are attached several definitions of words used through this report.

Demography

The statistical study of human population especially with reference to size and density, distribution, and vital statistics.

Epidemiology

(1) a branch of medical science that deals with the incidence, distribution, and control of disease in a population; (2) the sum of the factors controlling the presence or absence of a disease or pathogen.

Etiology

(1) all of the causes of a disease or abnormal condition; (2) a branch of knowledge dealing with causes.

I'm using the present format to highlight a few of the multiple areas and questions and issues that coalesce into an impressive array of data and opinions that point to a reasonable conclusion. And I am well aware of what happened to Socrates for asking so many "whys."

Why did 40 or 50 percent of the POWs in the Philippines and Korea die in the 3½ year period of imprisonment? What happened to their bodies that brought them to death? They nearly all died as human skeletons. In this case it has to be presumed that the body vitality was so damaged and weakened that life could no longer go on. I was there. I was a physician. Many died under my impotent care. The men who did not die were most of the time identical in appearance, emaciation and disease. Why can we assume that the bodies and psyche of the survivors were and are left unscathed?

Why has the death rate of the World War II Far East exceeded the death rate of the general VA population? These were proven survivors. Why did they die before their non-POW peers?

Why does the burden of proof fall on the surviving ex-POW and their protagonists that they have to prove a causal relationship to their physical and mental deficiencies that stemmed from known extreme deprivation? Isn't it just as reasonable that the others (in this case the VA) should provide an explanation of how the human body and mind can be so physically and mentally traumatized that it could not be damaged? Let it be understood that all POWs were exposed to all the same conditions.

Why do former POWs have a higher incidence of service-connected disability?

Why do former European theater POWs show significantly higher disability than other World War II veterans in the same theater?

Why is the most prevalent service-connected condition of former POWs anxiety neurosis?

Why have foreign governments accepted the causal relationship of the POW experience as evidence of later physical and mental deficiencies in ex-POWs and provided compensation without the individual having to prove the "scientific" relationship?

Why do former POWs have a significantly higher incidence and more severe disabilities than non-POW veterans?

Why did the former European POWs who were hospitalized for malnutrition have an increased rate of mortality due to trauma, tuberculosis, and cirrhosis while those POWs without malnutrition have no increased rate of mortality? (Dean Nefzger, NAS/NRC)

Why did the NAS/NRC Beebe study in 1965 show a significantly greater percent of former European theater POWs over non-POW veterans being compensated for service-connected disability to the following conditions: malnutrition (avitaminosis), arthritis, residuals of frozen feet, scars, and anxiety neurosis? Also, 11.4 percent of all former European theater POWs were being compensated for anxiety neurosis as opposed to 3.2 percent of the European theater veteran control group. Why again in 1979 did Beebe find 13.6 percent anxiety neurosis in the POW group and 6.19 percent in the European non-POW group?

Why did the former Pacific theater POWs have a statistically significant higher death rate from tuberculosis, accidents, and suicide the first five years after liberation as opposed to the non-POW Pacific theater group? (Cohen & Cooper)

Why did Nefzger find in the period 1953 to 1965 tuberculosis and trauma continued to be the major significant causes of death along with cirrhosis in the Pacific theater POW group? Keehn confirmed Nefzger's findings but not after the mid-fifties.

Why did the former Pacific POWs manifest a significant greater morbidity rate from TB and other infective diseases as well as nerve inflammation (neuritis), peripheral neuropathy, gastrointestinal, genitourinary, and orthopedic problems and prevalent arteriosclerotic heart disease through 1965 with Beebe's NAS studies?

Why does the most recent NAS/NRC (Beebe) morbidity study show that the Pacific theater POWs suffer from a significantly greater amount of service-connected disabilities than the matched Pacific group and general veteran populations? The disabilities are arthritis and back disorders, systemic diseases (avitaminosis, Beri Beri), bronchitis, tuberculosis, cardiovascular symptoms, residuals of frozen feet, gastrointestinal diseases (peptic ulcer, gastritis, amebiasis, dysentery, hemorrhoids, hepatitis), genitourinary problems (prostate gland infection), skin disorders (scars, dermophytosis), neurological disorders (peripheral neuropathy) and psychiatric problems (anxiety neurosis). The most prevalent conditions were malaria 27.0 percent and anxiety neurosis 25.8 percent. The Pacific control group was 11.2 percent and 5.0 percent for the two conditions (Beebe).

Why are the findings similar in the Korea veterans who suffered the same types and degree of privations as the Pacific World War II POWs?

The following is a summary statement from the POW Study of Former Prisoners of War published by the Veterans Administration in May 1980.

"The available mortality and morbidity data on the types and severity of former POW disabilities from repatriation to the present time indicates that the congressional concern about former POWs, especially those of World War II Pacific theater, having a significantly higher incidence and greater variety of diseases attributable to internment is well-founded. Evidence to substantiate this concern comes from the National Academy of Sciences and VA mortality/morbidity data. Considering the severity of former POW disabilities which show that Pacific ex-POWs are the most severely disabled POW group, followed closely by the former Korea POWs. While former European POWs are not as disabled as former Pacific or Korean POWs, they are more disabled than other World War II veterans. Development of disability of former Vietnam POWs who were held longer than any other group of POWs under study must await the completion of current ongoing studies."

STATISTICALLY SIGNIFICANT SERVICE-CONNECTED DISABILITIES AMONG FORMER POWs 1946–79

World War II		Korean Conflict	Vietnam
Europe	Pacific		
Anxiety neurosis	Anxiety neurosis	Anxiety neurosis	Currently being studied
Avitaminosis	Avitaminosis	Avitaminosis	
Arthritis	Arthritis	Arthritis	
Frozen feet residuals			
Scars	Skin diseases		
	Beri Beri		
	Pellagra		
	Malaria		
	Eye diseases		
	Respiratory diseases		
	Gastrointestinal diseases		
	Genitourinary diseases		
	Psychoneurological diseases		
	Cardiovascular diseases		

Why did the World Veterans Association in 1961 International Conference on the Later Effects of Imprisonment and Deportation identify a process of "premature aging" characterized by memory deficits, decreased powers of concentration, and increased fatigue in former World War II concentration camps and POWs? Why did they state, "In conclusion, the conference was of the opinion that there exists ailments and disabilities which appear long afterwards among former POWs who lived under exceptional conditions of stress?" The conference was of the opinion on the basis of the above medical conclusions that it is necessary to eliminate for the persons concerned all legal time limits for submitting applications in connection with disabilities.

Why do Eitinger and Strom in a 20-year follow-up of Norwegian political prisoners (really civilian resisters) deported to Germany during World War II report a significantly higher morbidity and mortality rate in the prisoner group as compared to the Norwegian general population and control group? In particular, there was a significant higher morbidity rate for diseases of the lungs, nerves, digestive tract, muscle, and bones. The most excessive cause of death among the prisoners compared to controls was tuberculosis.

Why would the Canadian POWs from the Far East and Fisher find spinal degeneration in the post mortem examination of 11 Canadian POWs performed 4-7 years after liberation?

Why in a 19 year follow-up study of 100 Canadian POWs of the Japanese matched with their brothers with World War II wartime service were 95 out of the 100 POWs granted pension entitlement by the Canadian Pension Commission as opposed to none in the non-POW matched brothers group?

Why if there is increasing current evidence of immunological deficiencies resulting from stress is this not applicable to the POW, both during and after the POW period? Why could not this stress factor not have contributed to the high morbidity rate and mortality rate both during and after incarceration? Why is it not to be expected that past severe prolonged physical and psychological trauma could generate more disease and death? (See "Stress in Health and Disease" edited by Michael R. Zales, M.D.)

This entire matter cannot be comprehended or dealt with fairly without understanding an acceptance of epidemiologic evidence. Probably the most important epidemiological medical issue today is the wide medical and lay acceptance of the relationship of cigarette smoking and cancer of the lung and possibly associated emphysema and heart disease. While it is true that no single case of cancer of the lung has been able to be directly and causally assigned to the smoking of cigarettes, a heavy weight of evidence epidemiologically points to the connection. The broad statistics clearly show that the greater the number of cigarettes and the longer period of time consumed, the greater the incidence of cancer of the lung. Most of the medical profession accepts this finding and it is part of the Public Health Service program and public advice.

While there is no direct and specific evidence to demonstrate the relationship of alcohol consumption to cirrhosis of the liver, it is accepted by most medical specialists on an epidemiologic basis that excessive alcohol ingested does in effect cause cirrhosis of the liver.

The increased incidence of abnormalities including cancer of the urogenital system in young women whose mothers were given diethylstilbesterol (DES) while pregnant has led many medical experts to conclude a causal relationship on a epidemiological basis. The abnormalities have been found in significantly larger numbers of young women whose mothers took DES.

Why is the situation with amputees any different from the same application to the POW? In our 1983 report we stated as follows: "We believe that the medical and statistical evidence is beyond a substantial doubt, well past speculation, and well into the range of probability. In addition, we believe that ample precedence exists to direct additional presumptions. The decision on service-connecting cardiovascular disease to service-connected limb amputations was made on the basis of an epidemiological study conducted for the VA by the National Academy of Sciences. Service-Connected Traumatic Limb Amputations and Subsequent Mortality from Cardiovascular Diseases and Other Causes of Death, December 11, 1978, determined that there is a statistically significant excess risk among proximal amputees for overall mortality, deaths due to all diseases, cancer of the buccal cavity and pharynx, diabetes melitus, and cardiovascular diseases including in particular ischemic heart diseases. This evidence was used to grant presumption of service-connection for amputees. Similar, equally strong evidence is available on former POW disabilities and we recommend that additional presumptions be directed for them."

Why is it postulated now that many of the Ethiopians who have been starving and then survive that the experience will cause permanent damage and that they can be expected to live shorter lives?

Before Goldberger in the South earlier in the present century discovered the cause of pellagra he had no knowledge of its cause. His discovery was purely on an epidemiologic basis. He observed that the disease was greatest in the poor whose diet was primarily cornpone and backfat. He then improved the diet and established the cause. Later it was found related primarily to vitamin B-2 (nicotinic acid).

During the past year in a small meeting of some of the members of the Advisory Committee with the previous medical director of the VA, the question of epidemiology was raised. In relation to cigarette smoking and cancer of the lung he stated that he did not accept the causal relationship of smoking and lung cancer. It is therefore presumed that this thinking represents the medical thinking in the medical department of the Veterans Administration.

The state-of-the-art of medicine has not reached the point where it can explain everything and that includes the long-range delayed effects on people exposed to catastrophic deprivation. It was not long ago that malaria was thought to come from the bad air in the swamps, that epilepsy and mental disease was due to evil spirits, that the plague was visited from on high, that the unknown germ had nothing to do with typhoid, tetanus, diphtheria, gangrene, pneumonia, and other devastating killers of mankind. Semmelweis in the middle of the last century before germs were discovered was virtually ostracized because he observed that more women in delivery developed puerperal sepsis (childbirth fever) and died when they delivered in the hospital than if they delivered at home. No proof, just epidemiology. Actually the infection in the hospitals was passed from delivering mother to delivering mother.

After having been through the full POW experience myself, having treated thousands of men, having impotently ushered many men over the line to death, having seen many of the survivors, having read extensively the medical literature in the U.S. and abroad, and having discussed the entire medical issues with many highly competent physicians, I can only conclude that there are many as yet unidentified residual traumata from the deprivation experience that have and will continue to harrass and haunt the individual survivor to his last day of life.

If one accepts (1) the demographic and epidemiologic data as a valid, significant, and essential part of medicine; (2) the considerable statistical support of statistical data in the previous material presented; and (3) the intent of Congress and express practice of the VA regarding benefit of the doubt and presumption on the side of the former POW, the conclusion would seem obvious.

If it be true that this small group of survivors were subjected to severe, prolonged deprivation of food and medicine, severe, prolonged physical and emotional illness, and they were; if it be true that statistical evidence supports a clearly higher incidence of physical and emotional illness, than their veteran counterpart, and it is clearly demonstrable; if it be true that demographic and epidemiologic evidence of higher incidence of disease and death is clearly evident in this group, and this has been clearly demonstrated; and if it be true the demographic and epidemiological factors are a legitimate part of medical thinking and practice, and these are denied then we are flying in the face of logic, denying and disavowing logic and entering a no think state which is mentally primative and ultimately catastrophic.

The position we have taken is not a isolated one. Medicine is at best an inexact science. I have striven my whole life to recognize logic and live by it. As a psychiatrist for many years I have seen what happens when people lose their logic and act accordingly. I for one cannot abandon a position of logic. Let those who abandon logic set forth their contravening explanations other than arbitrary denial. I for one cannot back away from the predominant weight of medical evidence and must therefore adhere to our previously taken positions. I have had cordial and mutually respected relationships with all of the medical staff at all levels of the VA. They have been highly competent, hard working, and efficient and cooperative. The impasse is brought about by an honest intellectual difference of opinion plus the above. There is nothing new, unusual, or bad about differences of opinion, especially in the field of medicine. It has been thus since the dawn of history. They are entitled to their point of view and we are entitled to ours. Dr. Beeson and Woodward are two great deans of modern medicine. Dr. Kumin is a younger, brilliant, highly knowledgeable and extremely competent well-informed teacher and clinician. Dr. Mitchell has been very well-versed in POW matters.

The VA is necessarily a vast, monolithic government structure with all of the usual inbuilt mechanisms to maintain the status quo and resist new or wholly unproven concepts and changes. The Congress, on the other hand, has vast latitudes to effect change depending upon trends, levels of public interest, and the changing fortunes of national fiscal liability.

Each has a responsibility to their constituents and attempts to maintain their integrity by their actions just as we have ours.

These reflections and opinions represent my honest beliefs and convictions. I cannot claim infallibility, but I do claim full integrity. There is no way I cannot believe what I believe as stated through this communication. I am perfectly willing to argue the case in depth with the VA medical members with whom I have a good respect and relationship, with congressional staff and congressional committees at any time.

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SURVIVAL FACTORS IN AMERICAN PRISONERS OF WAR OF THE JAPANESE[1]

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I. INTRODUCTION

The following comments are based on a 3½-year period of firsthand observations on American prisoners of war of the Japanese taken in the Philippine Islands in 1942. The writer served as a Medical Officer in prison camps in the Philippine Islands and Japan with members of the 30,000 American military prisoners captured by the Japanese Imperial Army with the fall of Bataan and Corregidor in April and May of 1942. The period of imprisonment lasted for 3½ years, until September 1945.

It is hoped that, with the passage of several years' time, and some increase in psychiatric knowledge and experience in the writer, a more balanced perspective has been achieved and made possible a more accurate and meaningful report.

Approximately 12,000 or 40% of the 30,000 men of the Army, Navy, and Marine Corps survived the period of imprisonment. It is the purpose of the present article to outline the factors that made survival difficult and to point out the individual qualities that most favored individual survival.

During the 5 months of active combat (December 8, 1941, to May 6, 1942), the men were exposed to inadequate food intake, active combat conditions, tropical weather, anxiety induced by awareness of an inferior military position, frequent poor leadership, and physical disease in the form of malaria, dysentery, and vitamin deficiencies.

The ignominy of capture with its attending emotional impact came on April 9, 1942, for the forces on Bataan, P. I., and on May 6, 1942, for the forces on Corregidor, P. I.

Our national group experience accustoms us to protection of individual rights and recourse to justice. The members of this group found themselves suddenly deprived of name, rank, identity, justice, and any claim to being treated as human beings. Although physical disease and the shortages of food, water, and medicine were at their highest during this period, emotional shock and reactive depression played a great part in individual inability to cope with physical symptoms and disease, and undoubtedly contributed much to the massive death rate (approximately 4,000 of the 30,000 American prisoners) during the first months of imprisonment from April to September 1942.

II. CONDITIONS OF IMPRISONMENT

Conditions of imprisonment varied from time to time in different places and with different groups. In general there was shortage, wearisome sameness, and deficiency of food; much physical misery and disease; squalid living conditions; fear and despair; horrible monotony almost completely unrelieved by pleasurable interludes; inadequate clothing and cleansing facilities; temperature extremes; and physical abuse.

Food consisted primarily of rice and soup with occasional very small amounts of meat, dry fish, or vegetable. The insufficient quantity resulted in constant hunger and loss of weight. The insufficient quality took its toll in vitamin deficiency diseases, weakness, and many deaths. Hungry men were constantly reminded of their own nearness to death by observing the steady relentless march to death of their comrades. The death rate in the main prisoner camp at Cabanatuan, P. I., was between 40 to 60 per day in a population of 6,000-9,000, or roughly 1% per day during the months of June, July, and August of 1942. Hungry men were often reduced to attitudes and actions incompatible with their own previously accepted levels of behavior and self-respect. Men quibbled over portions of food, were suspicious of those who were in more favored positions than themselves, participated in unethical barter, took advantage of less clever or enterprising fellow prisoners, stole, rummaged in garbage, and even curried the favor of their detested captors. There was a great distortion of previous personality as manifested by increased irritability, unfriendliness, and sullen withdrawal(1). Hungry, threatened men often found it difficult to expand the horizon of their thinking and feeling beyond the next bowl of rice. Added to this hunger was the haunting fear that the supply of food might at any time with little cause be reduced or even stopped.

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[1] Read at the 108th annual meeting of The American Psychiatric Association, Atlantic City, N. J., May 12-16, 1952.

The opinions expressed in this paper are those of the author and do not reflect official opinion of the Navy Department.

Disease was abundant(2). Fever, chills, malaise, pain, anorexia, abdominal cramps from recurrent malaria (acquired in combat), and dysentery plagued nearly all and killed thousands. Treatment was rarely adequate. Physical work was often required of men suffering with physical illness, which usually aggravated physical symptoms and hastened demoralization and death. Beriberi contributed symptoms of painful feet, anorexia, cardiac failure, loss of vision and led at times to death. With xerophthalmia came sore eyes, corneal ulcers, and subsequent impaired vision. In addition there were assorted outbreaks of diphtheria, flu, typhoid fever, along with tuberculosis, pneumonia, and various surgical conditions and their complications. Separate or associated with the above diseases, most men experienced bouts of apathy or depression. These ranged from slight to prolonged deep depressions where there was a loss of interest in living and lack of willingness or ability to marshal the powers of will necessary to combat disease. An ever-present sign of fatal withdrawal occurred 3 to 4 days before death when the man pulled his covers up over his head and lay passive, quiet, and refusing food. In some such cases active measures were life saving—these included support to the ego with praise, talk about the man's folks at home with inference of his responsibility, indulging his extreme dependence, and these failing, systematic prodding to anger. It was fascinating to watch this last mechanism operate within the group as a group survival mechanism.

Facilities for care of the sick were crude and primitive. Medical care was highly inadequate; prisoner doctors were given little latitude in treatment and were usually not supplied with adequate medicine to deal with the diseases present.

Living conditions were uniformly miserable. Men were exposed to extremes of temperatures, heat in the tropics and cold in the northern climates. Clothing, bedding, and housing were insufficient and contributed much misery. Camps were dank, dismal, and dreary. Lack of soap and warm water fostered troublesome skin lesions. Body lice and fleas were well fed and multiplied in abundance. Delousing facilities were almost nil. Tired, weak, sick men performed hard physical work on farms, in factories, ship yards, docks, coal and copper mines.

There were many complex psychological and mental handicaps to torment the men further. One of the most distressing features was the highly indefinite period of incarceration. The future offered only visions of continued hunger, cold, disease, forced labor, and continued subservience in the face of shouting, slappings, and beatings. All men were envious of prisoners at home who were serving known terms. The ennui and monotony of imprisonment were similar to, but deeper than that experienced episodically by combat troops. Strong hostility naturally arose from the extreme frustration of involuntary enforced incarceration. Little could be done with these hostile feelings. It was necessary to retain kindly feeling to the mother country for there alone lay ultimate salvation. It was not possible to demonstrate recognizable signs of hostility to the captors for obvious reasons. Therefore, where there were mixed groups of Allied prisoners, much hostility was turned from group to group and in other instances to individuals within the group. There was no escape from continued daily contacts with irritating incompatible fellow prisoners. In many cases hostile feelings were obviously turned inward and joined with appropriate feelings of frustration to produce serious waves of depression. All men experienced a smothering hemmed-in feeling with strong yearning for freedom of movement and freedom from oppression. The sight of sickness and death of friends increased the burden of many. Self-pity, which some indulged, was highly dangerous to life. Lack of specific knowledge of the course and state of the war and the infrequency of news from home further aggravated the sense of isolation and abandonment.

Under the existing conditions, the absence of sex did not seem to create serious or widespread problems. In this situation, it can be safely said, the sex drive varied in direct proportion to the food supply, and in inverse proportion to hunger. When the men were experiencing anxiety, depression, disease, or hunger, sexual drive was minimal and in many cases nonexistent(3). During periods of improved food intake and improved health, as observed at the Cabanatuan Prison Camp from February of 1943 to October 1943, sexual rejuvenescence was apparent. Sexual interest was reflected by an increased incidence of nocturnal emissions, by masturbation, and by homosexual practices—overt in a small susceptible group, covert in a much larger number of the men. Camp plays placed emphasis on female impersonations and female roles. Homosexual practices became a subject of group knowledge and discussion and almost reached a level where internal official measures needed to be applied. The problem disappeared spontaneously and rapidly with the depreciation of the food supply. Some men went through the imprisonment experience with a greatly reduced or absent sexual drive—some, for example, experienced no erections for as long as a year at a time. Some continued masturbation irregularly through the entire period. The deprivation of sex was not a major or serious problem to most men under the circumstances.

There were many direct physical and moral abuses from the Japanese. At least 90% of the men received some direct physical punishment at some time during their imprisonment. Punishment was meted out mostly by low-ranking soldiers or ex-soldier prison guards and less often but frequently by higher ranking enlisted soldiers and officers. The reasons for punishment varied from none whatever to violations of orders. When it is realized that race hatred in the Oriental had been built up to an intense level over the preceding generations it is not difficult to see how much nonspecific violence was directed to the white prisoners. Prisoners represented the actual physical presence of the much hated white race. This, combined with a considerable capacity for sadistic behavior in the Japanese personality, accounted for the infliction of much physical abuse on the prisoners. All prisoners were required to salute all Japanese military when covered and to bow stiffly from the waist if uncovered. Failure to do so or even imperfect technique brought punishment. The favorite and universal Japanese approach to asserting dominance consisted of a loud raucous exclamatory "Kioski" (Attention!) followed by fierce animalistic fury of incomprehensible shouting in Japanese topped off with slapping or hitting. The recipient was required to remain standing at attention, silent and motionless. Any deviation from this called for greater beatings or imprisonment. When the ire of the punisher subsided sufficiently or the victim was no longer able to stand, the session was terminated. Slapping at times was administered with sticks, straps, wooden clogs, or any convenient wieldable object. Every unit, no matter how small, harbored one strongly sadistic creature whose main daily satisfaction was derived from inflicting beatings. Even the most cautious and circumspect prisoners for one reason or another came in for some degree of punishment. There were many obvious efforts to break the morale and spirit of the prisoner group. Clothing, food, mail, and Red Cross packages were often intentionally seized, destroyed, or kept from the men over long periods when they were bitterly needed. Men marched through the city streets of Japan long distances to work, tattered, torn, and weak. Physical exercise in the form of calisthenics was demanded of all men before, during, and at the end of the day's hard work. Threatening speeches were made to individuals and groups with humiliating implications. For minor reasons, men were placed in camp jails and solitary confinement with reduced food and cover. Many developed serious illness, including pneumonia, dysentery, and gangrene of the extremities from this treatment. Several executions were held openly on prisoners who had tried to escape from the Cabanatuan Prison Camp. Men were transported in unmarked ships and housed in unmarked camps ashore. At various stages of the war, prisoners ashore and in transit were subjected to bombings by our own planes, torpedoeing by our own submarines, and shelling from shore installations. Several thousand men were lost in this manner. Some camps were worse than others. It was not unusual for men to break their bones in order to get out of such a "worse" camp and be taken to another area; one such area was Palawan, P. I., where nearly 200 men were finally herded into a shack, burned or shot to death. Only a few survived to tell the tale.

To summarize, the major factors that had to be dealt with in order to survive were these: the initial shock and subsequent reactive depression induced by being taken prisoner by Oriental people; the feeling of being deserted and abandoned by one's own people; the severe deprivation of food, warmth, clothes, living comforts, and sense of respectability; the constant intimidation and physical beatings from the captors; loss of self-respect and the respect for others; the day-to-day uncertainty of livelihood and the vague indeterminable unknown future date of deliverance.

III. SURVIVAL FACTORS

The "instinct" of self-preservation in man and animals is often used to describe an unwitting or subconscious drive to retain a hold on life even in the face of threat. "Instinct" applied to man does not provide the entire answer. Granted that we derive some blind basic drive for continued life from our animal ancestry, we also by virtue of reason, foresight, and capacity to perform rational acts are capable of bringing life under conscious will or control. This imprisonment experience provided a unique opportunity to observe what happens to the human will to live under prolonged severe stress. What is the will to live? Is it stronger in one than in another? If so, why? Can it be modified or influenced? Does everyone have a breaking point where he is willing to give up? Was the stress of this experience materially different from that of everyday life?

Much has been written of the will. Without making detailed reference to philosophic, religious, or psychiatric concepts of free will, it is here advanced that what freedom of the conscious will man can muster and operate was shown to be a tremendous positive factor in survival. Where the will to live was for any reason weak, death seemed to come readily even with lesser physical ailments. On the other hand, where the will was firm even in the presence of serious physical illness, life often continued. Since the will to live was of primary importance it might be worth stating some factors that seemed to sustain that will in the presence of prolonged stress of this particular type. In brief, willingness to continue living depended on the effectiveness of psychologic defenses in preserving the strength of the ego and feelings of self-esteem. It was essential to conceive of one's self as something better than the environment implied. It was important to look forward and backward and retain an active identification with one's home countrymen instead of with the miserable prisoner group. Where this will to live was weak in the beginning or defenses were poor or both, chances for survival were diminished. The individuals who too closely merged with their prison environment and who as prisoners felt like prisoners fared badly. A successful defense in this area was a persistent recollection that one was an American, a westerner, a Texan, a soldier, an officer, a father, an artilleryman, or some other acceptable ego-supporting concept. The will to live in everyday ordinary circumstances seems to be sustained by the existence of a favorable balance of everyday satisfaction with the past, present, and some reasonable hope for the future. These men had to overlook, repress, or ignore the present, and place undue emphasis on past and future(4).

The conscious and subconscious motivational factors for continuing life were by far the most important features favoring survival. Individual differences ranged from giving up in the very beginning at the mere prospect of imprisonment to tenacious holding on through all the vicissitudes in the years of travail mentioned earlier. Those who gave up earliest and easiest were the younger men, viz., in the 18-22 years span, who lacked the maturity, philosophic concepts, fortitude, independence, and the buffering effect of at least several years of military experience, which they needed to withstand the initial shock. It is noteworthy that this age group corresponds to the age group with the highest incidence of combat fatigue in combat conditions(5). The nature of the conscious motivation was unimportant. Some had an extreme desire to see and be with loved ones. Some lived for the opportunity of again tasting the pleasures of life once taken so much for granted—a cool beer, hot dogs, a steak dinner, home cooking, a new car, a clean bed with a mattress, the home town, the mountains, or just plain freedom. Some were motivated primarily by a stubborn refusal to be dominated and overcome by inferior people.

The more men experienced depression and regression with physical illness, the more readily did they part with the strong desire to live and enjoy the future. Those who went into illness with some realistic appraisal of the gravity of the situation and had a firm intention to hold out as long as possible were more likely to survive the illness. On the other side, those who developed depression for psychologic reasons were very likely to rapidly develop physical illness. At times it appeared simply that some were naturally weak willed and others brave. In a very general way it can be said that a previous stable personality was an asset. Defensive mechanisms used to combat previous troubles of lesser degree were drawn upon again. Those included the following: escape as controlled autism, study, and drama; refusal to face reality, as overoptimism (a hazardous defense in this situation), overpessimism (generally more effective); "be friendly and on good terms with the enemy then he won't hurt you;" repression and suppression of knowledge of the ever-present danger of death with a kind of obsessive conviction that one would make it somehow; and pleasurable fantasies of the enemy taking a beating elsewhere in battle.

Cleverness, adroitness of thinking and dealing with people, and general cunning were often great contributing factors to survival whereas pure intelligence unrelated to interpersonal dealing and long-range prediction was of less advantage. The more sense of humor an individual was able to retain the greater were his chances of survival. It is difficult to state whether the capacity to see humor even in sordid situations contributed to livelihood and survival or whether it was simply that those people who had retained a sense of humor were strong in other ways that aided survival. A well-controlled and strong fantasy life was helpful for many when correctly applied in an optimistic direction. Good discriminatory judgment and emotional balance were obvious advantages. A willingness and desire to keep busy but not to work too hard in order to conserve energy were highly desirable. Courage was essential but too much could be troublesome unless applied with a long-range view. Direct fighting-back or escape were in most instances completely out of the realm of possibility and only brought further travail and in some cases tragedy. Many were helped to tolerate the misery of confinement by finding an effective but disguised way of striking back at their captors. These measures included surreptitious acquiring of news; bribing of Japanese guards; utilizing knowledge of the natural Japanese schizoid-paranoid temperament by playing one against the other; smuggling news, letters, food, Japanese dictionaries, and medicines; and in some instances successful contamination of the captor's food.

Occasionally an individual would develop a depressive reaction in which he would lose interest in himself and his future, which was reflected in quiet or sullen withdrawal from the group, filth of body and clothes, trading of food for cigarettes, slowing of work rate to a level that invariably invited physical abuse from the Japanese and an expressed attitude of not giving a damn or what's the use. If this attitude was not met with firm resistance by companions, camp leaders, or medical personnel, death inevitably resulted. The most successful measures in combating this reaction included forced hot soap-and-water bathing, shaving and delousing, special appetizing food, obtaining a few days rest in camp, and if possible temporarily easier work conditions, a mixture of kindly sympathetic interest and anger-inducing attitudes. Victory was assured with the first sign of a smile or evidence of pique.

There were spontaneous undirected protective group mechanisms that favored survival. As with all groups oppressed by a common, easily recognized oppressing force, here too an automatic group cohesive force eventually developed. This force was in conflict at times with measures that favored individual survival, and was handled differently by different individuals. The clearest example is in attitudes toward escape. All men were grouped into shooting squads of ten. If one or more of the group escaped, the remainder were to be shot. Thus escape or attempted escape simultaneously meant jeopardizing the life of one's fellow prisoners. Attempts at escape in the P. I. and Japan were infrequent and rarely successful. I have immediate personal knowledge of only 3 separate escape attempts involving 5, 1, and 2 men. All were apprehended and executed. In 2 of these instances the remaining members of the group were punished but not shot. I believe in most instances the major deterring influence to escape was realization of the overwhelming odds against success with sure death if recaptured. Some were deterred to some extent by knowledge of punishment to the remaining members of their group. Another example of subconscious group protective reaction was the relative infrequency of fighting between individuals within the prisoner groups, even in the face of strong provocation. The infrequency seemed greater than could be explained by the lowered physical state. Another group mechanism operated in the selection of leaders where this was permitted or possible. The small margin of error allowed the groups and the drastic effect of mismanagement influenced departure from older group or sectional bias in favor of selecting and supporting more able, honest, and courageous leaders.

Something must be said of differences in individual constitution. In general it seemed that thick, dark, stocky individuals seemed to wear better than thin, small-boned, tall, slender, delicate-framed individuals. Emotionally, the plodding, unresponsive, insensitive individuals did well, while more sensitive, previously sheltered, dependent individuals fared badly. Some of the sensitive individuals successfully balanced their sensitivity with humor or philosophic considerations. Pure luck, along with opportunism, in some instances, contributed to survival for many. Officers and professional personnel in general fared better than average due to the combination of higher natural endowment, and less rigorous physical work. Failures in adjustment were most apparent in the 18-to-23-year-old group who had little or no previous military experience and much previous overprotection. These men demonstrated marked inability to fight physical diseases and the initial shock of depression of captivity. A minimum of 8 or 10 years of military service seemed to provide some buffer against the physical and emotional hardships of imprisonment.

The next most vulnerable group was probably in the 45-to-55-year span and then 33-45, 55 plus, and 23-33 in order with the 23-33 year span having the most favorable status for survival. It might be noted that many of these men who survived made a gradual transition from the very different category of soldier to professional prisoner of war.

It is interesting to consider how certain psychiatric groups handled confinement. The huge majority of psychotic manifestations were seen as part of severe organic disease such as pellagra, cerebral forms of malaria, and acute toxic states. A small number with an incidence of roughly 1 per 1,000 per year could be classified as functional psychoses. This latter group fared badly and usually died of intercurrent disease. Some of the same individuals who demonstrated precaptive neurotic patterns of psychosomatic gastrointestinal and vascular symptoms, fugue states, hysterical manifestations, marked tension states in combat due to fear of being killed showed remarkably few disruptive or disabling symptoms under prisoner conditions. These individuals for a number of reasons were better able to accept and endure the quiet passive unassertive life with its long-range threat over the more hectic and often catastrophic aspects of active combat. The fact that relatively few demands were made upon them to exercise personal initiative and responsibility may have contributed much to their relative ease.

Suicide *per se* was rare. Many of those who died in response to the initial shock and during the course of disease were to some degree self-induced deaths of a passive nature. On the other hand active self-inflicted injury was rare. I know of only 3 active suicidal attempts. The first was an army officer who was found in his bed space in the morning exsanguinated from self-inflicted lacerated wounds of both wrists. One wrist cutting by an enlisted man was unsuccessful, and the other attempt occurred in a schizophrenic patient. It may be that the ever-present long-range threat to life satisfied transient impulses to death, which made it unnecessary for an individual further to act out self-destructive feelings or impulses.

Psychopathic personalities were interesting in that they managed exceedingly well when assigned to extra camp jobs to which they seemed to gravitate, such as driving trucks or taking care of odd personal jobs for the Japanese, but fared very badly when kept under the same rigid restrictions as the rest of the men. In the latter circumstance they almost invariably became involved with the Japanese by virtue of foolish aggression or stubborn resistance, and also aroused hostility in their fellow prisoners. These men would then develop some degree of depression and apathy and waste away physically, and to death if unchecked. Several known alcoholics made excellent prisoner adjustments and expressed their oral needs through incessant vocalizations both awake and asleep.

Men with obvious low intelligence often fared badly, owing to poor planning and rationing of food and energy, poor self-care, lack of friends, and receipt of more than average abuse from the captors. A few known overt homosexuals were observed to be in unusually good spirits during periods when they were able to practice their arts. Their adjustments at other times were on a par with their comrades of equal age, intelligence, and rate.

SUMMARY

The prolonged miserable circumstances of living during 3½ years of imprisonment as prisoners of war of the Japanese have been outlined. An estimated 12,000 of 30,000, or 40%, survived this experience unique in the history of American people. An attempt has been made to state some of the factors that seemed to the writer to influence survival favorably. These factors in summary consisted of a strong motivation for life with persistent exertion of will, good general intelligence, good constitution, emotional insensitivity or well-controlled and balanced sensitivity, a preserved sense of humor, a strong sense of obligation to others, controlled fantasy life, courage, successful active or passive resistance to the captors, luck, opportunism, and a few preceding years of military experience.

BIBLIOGRAPHY

1. Schiele, Burtrum, and Brozek, Joseph. Experimental neurosis resulting from starvation in man. Psychosom. Med., 10: 31, Jan.-Feb. 1948.

2. Nardini, J. E. Vitamin deficiency diseases in allied prisoners of war of the Japanese. U. S. Naval Med. Bull., 47: 272, March-April 1947.

3. Brill, N. Q. Neuro-psychiatric examination of military prisoners recovered from Japanese prison camps. Bull. U. S. Army Med. Dept., Vol. V, No. 4, April 1946.

4. Wolf, S., and Ripley, H. S. Reactions among allied prisoners of war subjected to three years of imprisonment and torture by the Japanese. Am. J. Psychiat., 104: 180, Sept. 1947.

5. Raines, G. N., and Kolb, L. C. Combat fatigue and war neuroses. U. S. Naval Med. Bull., 41: 923, Sept. 1943.

DISCUSSION

COL. RAWLEY E. CHAMBERS (Fort Sam Houston, Tex.)—Commander Nardini has given, as an eye witness and participant, an objective, accurate, comprehensive, and factual report. I have referred his paper to several ex-prisoners-of-war for comment and they have confirmed the observations reported in every respect, and have unanimously agreed with the conclusions drawn. The author is to be congratulated on having written a highly interesting and informative paper that should add much to our understanding of these survivors in their attempt to maintain an adequate adjustment since their liberation. It is to be noted that the author himself has taken every advantage of the factors noted in the paper and has apparently encountered no insurmountable difficulty in maintaining his ability to adjust.

Since 1946 I have had the opportunity to observe, examine, treat, and make disposition of large numbers of ex-prisoners-of-war, and also to have been associated with a considerable number who still remain on active service. As a result of these experiences, it is apparent that the clinical picture presented, when considered in the light of previous personality structure, follows a rather definite and clear-cut pattern.

With relatively few exceptions the presenting complaints are usually as follows: fatiguability, lack of ability to withstand frustration, frequent resort to alcohol and sedative drugs, low resistance to physical illness, neuritic-type pains in feet and hands and frequently edema of the ankles and feet, irritability and other manifestations in varying degree of emotional instability, and a need for preferential duty assignments. Psychosomatic symptoms are frequently present.

On physical examination remarkably little is found in the way of structural pathology. Fairly common, however, are the findings of impaired sensation in feet and hands in the form of real neuritic impairment or, most frequently, as subjective paraesthesias. In many cases definitely abnormal electroencephalograms are found. Undoubtedly these are frequently the residual effects of the brutal beatings to which the prisoners had been subjected. Quite often intestinal disturbances such as chronic diarrhea are noted—possibly amebic in origin, but usually with psychiatric connotations. Most noticeable are the manifestations of chronic anxiety.

No definite conclusions can be made as to the degree of physical impairment as distinguished from strictly functional disturbances because of the relatively few exhaustive pathological studies available. It is logical to assume that, as the result of long-continued chronic debilitating diseases and severe vitamin deprivation, certain changes in structure and function of the central nervous system and other organ systems may result and form the basis for the remarkably uniform symptom complex.

Finally, the findings in these cases bear out the statements of Commander Nardini as to the facts reported and the conclusions drawn. Again, I wish to congratulate the author on an excellent paper.

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The William C. Porter Lecture—1961[*]
Psychiatric Concepts of Prisoners of War Confinement

By
John E. Nardini, M.D.[†]

Introduction and General Comments

HAVING served 3½ years as a prisoner of war of the Japanese in World War II in the Philippine Islands and Japan from 1942 to 1945 and having worked as a psychiatrist on active duty in the U. S. Navy for the subsequent 15 years, the author feels in an excellent position to speak with both intense feeling and good knowledge on the problems of prisoners of war. Most former prisoners of war have felt the compelling need to explain their reactions and experiences but have soon found a painful sense of frustration at not being able to adequately explain their true emotional reactions. In prisoner of war experiences, as in many other unique personal experiences, survivors often subsequently try to seek out fellow survivors with whom to relate and empathize. Often, however, there are pathetically few remaining survivors. In this regard the Korean prisoners of war were reduced approximately by one-half, i.e. of the 7,200 captured about 3,000 survived and of the 30,000 World War II American prisoners of the Japanese in the Philippine Islands, approximately 16,000 survived. Allied prisoners of war of the Germans in World War II faired well for the most part. The Germans were signatories of the Geneva Conference regarding treatment of POW's, the Japanese were not.

Prisoners have been taken since the dawn of time. When the stronger force overwhelms the weaker force, there has always been, at least in the heat of engagement or shortly thereafter, a notable ambivalence about allowing the captives to remain alive and be useful or to kill them on the spot for pleasure or because it is inconvenient to keep them. Until rather recently little has been written about prisoners of war. This has always represented an inglorious type of human experience about which most nations have felt more comfortable in suppressing and keeping out of sight, much as leprosy, plague, social decay, defeat, etc. The prisoner of war has had rather few spokesmen over the years. Most prisoners prefer to remain unvocal in order to further suppress or repress unpleasant feelings associated with their experience. He experiences an uneasy feeling that somehow he has lost self prestige in this inglorious process. Few groups have a more miserable lot than the prisoner of war. Our own Civil War prisons described in the novel Andersonville,[1] the longstanding extensive mutual brutalities of German and Russian prisoners of war in World War II, and the American mistreatment at the hands of the Koreans, Chinese, and Japanese all bear horrible testimony to the utter miserableness of these experiences.

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[†] Dr. Nardini recently retired from the U. S. Naval Service in the grade of Captain, Medical Corps. He is now in private practice at 2401 H Street, N.W., Washington 7, D.C.

Why Does Man Imprison Man?

The most prominent longstanding historical reason has been safety. If the captive is held confined, he is neutralized and no longer represents a threat to the capturing force. Further reasons for imprisonment are: to provide punishment, not intended for prisoners of war but of primary importance in civil situations; to break the spirit, weaken the individual, bring him around to the captor's way of thinking and make him accept his social and political philosophy; to obtain cheap labor allowing the captor to feel satisfied, superior and safe; to get information against the enemy; to use as propaganda showing superior power over the enemy and to frighten the enemy into further submission. In this regard "brainwashing" became important with the communists in the Korean War.

What Are the Reactions of Prisoners?

When one is taken prisoner his first reaction is one of confusion, bewilderment and a sense of unreality. Man has struggled against the alien forces of life to obtain individual freedom over many, many centuries. Thus, when it is lost, he becomes aware of an overwhelming feeling of helplessness and defenselessness. He is also filled with feelings of shame, guilt, and belittlement. He fears that he will be regarded a failure, that he showed insufficient courage, and that he should have died fighting. The huge majority of prisoners of war do not give up individually but are surrendered as a unit by a commanding officer. Still none can escape a personal feeling of individual failure. It has never been quite determined at what point one can or should "honorably" give up in warfare. Usually those seated comfortably in administrative positions far, far from the scene of battle and much more concerned with political problems find it much easier to think and speak in terms of fighting to the last man than those engaged in the sometimes seemingly hopeless strategic or tactical situation. There is no ready means of making a clear choice of fighting to the deadly end or of surrendering either as an individual or a group as a practical expedient when the odds become patently impossible.

Modern man has immortalized last ditch stands to the death when the cause is "good," witness Leonidas at Thermopylae, Horatius at the bridge over the Tiber, Davy Crockett and his celebrated confederates at the Alamo, and our numerous Congressional Medal of Honor winners. The same desperate stand taken by bandits, desperadoes, or gangsters, however, invite no accolades. This self sacrificing heroism points up the idea that the welfare of the collective group has a greater value than the welfare of any individual member. The modern state no longer depending upon purely professional soldiers and mercenaries must promulgate this concept to its members successfully if it is to survive. This potential sacrifice of life must be made by each male individual to pay for his "freedom" in modern democratic society in contrast to earlier forms of group living represented by ancient tyranny and feudalism. It is this concept of sacrificing one's life that give men trouble when the chips are down and the game of war commences since it conflicts drastically with a far older and stronger force of self preservation. Vast social forces are required to keep the individual reminded of his larger duty. It is for this reason that prisoners removed from these social forces can and do more readily yield to selfish behavior and collaboration in an atmosphere such as the prison camp. The prisoner upon capture soon feels hostility and depression; anger at the mother country and the wish to blame someone—Generals, Congress, the President, etc.; an uncomfortable sensation of loss of identity; fears of survival; tension over the terrible conflict between the strong forces of self preservation, of keeping one's self alive at all costs (even at the expense of fellow prisoners), against the concept of maintaining decent interpersonal social relations with which he has lived all of his preceding life. There is no better place than a prisoner of war camp to note the terrible force that the feeling of self preservation has in man. There are few more discouraging sights than to see this win out over the more normal sense of decency that has taken man so many thousands of years to acquire. It is not difficult to understand how a man starving could bring himself to steal food from a starving bunkmate thus pushing his bunkmate closer to the brink of death in order to save himself, or how a prisoner might curry favor with the hated captor to gain advantage for himself against the welfare of his fellow prisoners. The extreme end point of the drive for self preservation to which only a few can reach, in view of the deeply repressed strong taboo, is cannibalism. While all of these antisocial acts can be understood, they are never accepted by the larger group. The strongest existing social force is brought to bear in such instances, namely, group ostracism which when well applied can bring death to the subject ostracized.[2] Of all experiences and stresses to which a prisoner of war is subjected probably the worst is the initial shock to this new status which rapidly forces upon him the painful awareness of threatened loss of identity. Very soon there follows, in addition, fear for his life from disease, abuse, neglect, new moves and new marches; the pain of forced physical work in the presence of great fatigue and serious illness; an increasing sense of loss of self respect because of his new lowly status; frequent depths of ennui, boredom, or depression; continual forced close association with his fellow men, many of whom he would not voluntarily choose to live with; unpleasant feelings associated with unavoidable alternating waves of optimism and pessimism; the many breaks in normal sanitation; watching his fellow prisoners in pain, disease and death; suffering extremes of physical and moral abuse along with the usual physical deprivation of cold, heat, starvation, insects, body lice; horrible monotony of miserable and insufficient food; foul odors; and inadequate clothing.[3] In fact, all conditions that man would prefer not to have happen to him can and do happen when he becomes a prisoner of war. It should be readily apparent that the ability to withstand this type of punishment is not universal. This, undoubtedly, contributes to a vast extent, to the high death rate, particularly in the earlier phases of imprisonment where the spirit is unable to measure up to this extreme trauma of threat to one's identity and the overwhelming sense of helplessness in the face of so much disaster. The death rate is notably high in the first six weeks of imprisonment[4] as described elsewhere in detail with both prisoners of war and political prisoners in World War II. Those too young (18-22 years)[5] and weak of spirit are the first to die. Older, better disciplined, more experienced and mature individuals who have learned more of themselves and those who have had more military discipline tend to survive best under this initial impact.

The question is often raised by those who have never been prisoners, "I wonder how I would make out as a prisoner—what my reactions would be?" It is very difficult indeed to answer this question because individuals of many types of personalities are able to survive the above stresses. It would be very difficult to pick out certain specific ingredients of personality as a common denominator. In general, one certainly needs a philosophic, fatalistic view along with the ability to live for the very moment but still plan for the future without too strong a demand that it come to pass today or tomorrow. One also needs a sufficiently flexible attitude to allow a shift to a new view as real new circumstances might require. In general, the more self respect one can maintain the more possible it is to remain feeling more adequate even in the face of the most alien external surrounding. This is, however, admittedly difficult when one is ill clad, cold, hungry, sick, fearful, depressed, beaten and filled with feelings of helplessness and/or hopelessness.

The author was exposed to a most unusual circumstance of having served as a Battalion Medical Officer with 1,500 Marines for the year preceding World War II in peacetime garrison life in Shanghai, China, later in active combat for five months on Corregidor and Bataan, Philippine Islands, then to have been imprisoned with many of the same group for the next 3½ years and finally to have observed the course of some of these individuals over the subsequent 15 years of return to peacetime living either in the service or in civilian life. While it is true there are many who adjusted readily and well to all of these entirely different sets of circumstances, there were also many who adjusted well to one and poorly to another. There seemed to be very little correlation between these different levels of adjustment. Some who made very excellent garrison soldiers were miserable in combat, some who were excellent in combat made miserable prisoners of war, some who made excellent adjustment as prisoners of war failed miserably upon return to peacetime living again and ran afoul of close family relationships, alcohol and disciplinary difficulties. Many heroes of combat died in prison camp because of inability to adjust to that phase of life. Heroes of prison camp adjusted miserably upon return to the States. Some gay Lotharios and militant top sergeants in garrison life buckled like crazed soldiers in the face of enemy fire. Shy young aggressive country boys of peacetime life rose to the occasion of rapid maturation in combat and prison experience. It was and is most difficult to recognize and predict behavior in these various settings for the same people. Nevertheless, most former prisoners of war would feel confident that they could select from among their associates those individuals with whom they would prefer to take into another prisoner of war experience. It is of interest to note that the passive dependent individual often tended to do fairly well in prison camp since he was able to accept the passive role fairly readily, decisions were made for him, and he merely had to follow instructions to live. If, however, this were measured with great immaturity, he found a further constant need for reassurance to prop himself up with continual overoptimistic views. This dependent attitude contrasts with the normal assertive or aggressive individual and the aggressive psychopath. The more normally adjusted aggressive individual usually found ways to express his aggression in terms of sabotage, veiled hostility, or other covert acts against the enemy. The aggressive psychopath on the other hand lacking normal controls invariably developed a depressive reaction when he was finally constrained and bound down by the inevitable and final restrictions of confinement. The same psychopath would be in hot water in peacetime military service breaking rules and regulations and receiving regular punishment. In wartime he would often serve quite excellently by rustling hard-to-get food, equipment, and demonstrating effective combat aggression against the enemy. In prison camp, providing he were able to get special jobs, he also would do fairly well but when finally confronted with the full reality of restraint he tended to disintegrate into depression and apathy. Some individuals who had been accustomed to having depressive reactions made a fair adjustment since many of their guilt feelings were assuaged by the obvious punishment before them and if they were used to tolerating depression they were able to apply the same defense. Some known alcoholics unwittingly abstaining from alcohol did very well. Many homosexuals faired quite well. Those with mild paranoid trends made a fair adjustment since they were very persevering and found it easy to project blame onto their captor and were determined not to let him win out. Narcissistic individuals did not fair well, preoccupied with self preservation they were most vulnerable to siding with the enemy in some form of collaboration or acting against the interest of fellow prisoners which would usually invite group ostracism with serious end results to themselves.

WHAT ARE OPTIMAL QUALITIES TO BE A SUCCESSFUL PRISONER OF WAR?

As mentioned above, to survive as a prisoner of war requires the possession or capacity to develop a philosophic, fatalistic, but non-defeatist attitude and intense application of life's energies to the present. An ability to retain hope in the face of any hardship (this is a quality with which the physician in attendance at the death bed is familiar). A strong motivation to live such as love of wife and family, a strong sense of responsibility to family or toward fellow P.W.'s or country or God, a strong hate of the enemy, a zest for or love of life knowing that whatever there is to death there is in death no life, possibly even a fear of death—the nature of the motive is of no great importance only that there is a strong enough positive or negative motive. A proper balance between the great forces of self preservation and a genuine interest in the welfare of one's fellow man. A sense of humor. Tact. Moral courage. The ability to manage hostility and fight depression. A strong ego. A high tolerance level to pain and frustration. Minimal tension with dependence-independence feelings. Good intelligence. Enough inner resources to last out a long drought of outer stimuli. The intangible, indefinable, all inclusive will to live which in effect combines many of the above features.

THE PHYSICIAN AS A PRISONER OF WAR

How does the physician react as a prisoner of war with his combined personal and medical deprivations? In general, as a non-combatant, he may, at first, tend to feel somewhat less personally involved than the "fighting" man and more readily falls back on his role as a physician since he feels it makes little difference providing medical care for his men whether they are fighting or imprisoned. At the same time, he tends to feel more resentment at the shabby treatment to which he is subjected since he feels he should have a special status as a physician and non-combatant. Those physicians who are more identified with the military find their experience more akin to the non-medical personnel. In American wars the huge majority of physicians have been primarily and necessarily civilian oriented since only a small core of physicians constitute the regular corps of medical officers. For these reasons, while he finds it easier to accept prisoner status at first, later he finds it more difficult to accept the prisoner conditions as he finds himself unable to function effectively as a physician. He may react to this at first with some apathy, then depending upon his personality he rallies and doggedly does his best in a sort of "emergency" manner or retreats into a dull, dazed and defeated state of doing nothing. A few rare physicians in World War II in the Orient panicked out of fear of self preservation and sold precious desperately needed life saving drugs for food, money or favors to fellow captives and in some instances even to the captors.

In general, where the physician was able to retain his self concept as a physician and continue this role either in a self appointed or group designated capacity he tended to fare better in terms of maintaining a self sustaining emotional support. In general, the huge majority of physicians possessed those better integrated and adjusted qualities and took this direction.

The problem of administering to the mortally ill patients with little and often no effective medicine or other supportive care; of being forced to send mortally ill patients out to do physical labor ill clad in freezing weather; of valiantly striving to stand the strain of administering homeopathic amounts of inert agents (known to himself to be valueless) to desperately hopeful but mortally ill patients with an air of verve and confidence on his part; of listening to legitimate complaints of vitamin deficiency and other diseases the course of which he knew could only march inexorably onward to death in the prescribed period of time; of knowing so well the timetable of death in these cases and having the knowledge but not the means to intervene; of knowing the self same symptoms developing within himself; of finding it impossible to institute in many instances even simple preventive hygiene and sanitation; of dealing with his rising anger at his captors for their certain murder of his fellow prisoners in the guise of natural death; of watching the parade of death and knowing the mathematical certainty of death for all unless some change came about; of finding his captors to be callous, pitiless, indeed even covertly gleeful at the plight of his charges and completely unyielding to his pleas for understanding, medicine, and help; of feeling that somehow all this just couldn't be, that it must really be but a bad dream—as anyone can see would challenge the most stalwart physician who ever attempted to practice the healing art. These special added attractions are, of course, super-imposed upon the routine deprivation factors described elsewhere for all prisoners.

The prevalent diseases of the prisoner of war sound like an index to a textbook of medicine; however, there are certain steady favorites which include general malnutrition with emaciation, hypoproteinemia, the vitamin deficiency diseases of Scurvy, Pellagra, Beri Beri, Xeraphthalmia along with the dysenteries, respiratory diseases of pneumonia, flu, TB and a broad assortment of skin disorders. The emotional disorders seen are primarily those related to reactions of apathy, withdrawal and depression. Schizophrenic reactions and suicides occur with much less than average frequency. Hysterical reactions in the form of conversions occur but with less than average frequency.

PLACEBO EFFECT

Many useful, careful scientific experiments are being conducted under the auspices of the National Institute of Mental Health designed to shed light upon our understanding of the vast power of suggestion as noted in placebo effect.

In World War II in the Philippines the author and other physicians were in the unique and miserable situation of attempting to administer to a "ward," i.e. a bamboo shack of 100 seriously ill men with assorted severe symptoms of malaria, dysentery, beri beri, pellagra, scurvy and severe malnutrition. The daily death rate at the Cabanatuan prison camp in the Philippine Islands was at that time in July-September, 1942, 2-4% per day in this group. The Japanese brought into camp an assortment of medicines taken from civilian drug stores in the surrounding areas. The drug armentarium to treat 100 seriously and mortally ill men suffering with the above disorders consisted of 6 or 7 quinine pills, 5 or 6 aspirin pills, and generous amounts of Lydia Pinkham's Vegetable Compound, and Dr. Carter's pink pills for pale people. The men were at that time unaware of the proper treatment of these conditions and desperately wanted help. Thus, it was easy to lead them to believe that they were being administered good medicine in good faith. If the individual physician believed in the therapeutic advantage of this justifiable hoax there was effective reinforcement of the therapeutic effort. It was not possible to scientifically measure the effectiveness of this maneuver but in a gross way, it can be stated that in many instances the gain was just short of the miraculous even with killer diseases. Many individuals rendered hyper-suggestible by the force of circumstances were supported over a highly dangerous period believing they were being helped so that the normal bodily restorative processes were able to operate at an optimum level instead of being hindered by anxiety, fear, tension, and anorexia. I am certain many lives were thereby saved, at least for the time in question.

BRAIN WASHING

Much misunderstanding and unnecessary concern has arisen over this method of influencing the minds of men. The human mind is complex, imperfect, limited, highly developed and as yet imperfectly understood. It is capable of ridiculously easy suggestibility and also capable of inconceivable resistance to pain, suggestion, torture and deprivation even to death. The communist techniques of coercive interrogation (i.e. Brain washing of the Chinese Communists) utilizes a number of long known tools of forcing agreement from a captive human being. The primary aim is to soften the will of the captive to resist by inducing pain, fear and guilt. The prisoner may be locked in a dark or continually lit uncomfortable cold dank cell completely removed from all human contact except for guards and interrogators; forced to hold stationary positions to physical pain beyond endurance; suffer physical disorders untreated, e.g. wounds, swollen members, dysentery, etc.; semi-starvation with foul food; exposure to filth and vermin; threats of death and punishments, unending bleak and dismal confinement with alternating attitudes of insults, hostility and compassion; offer of better conditions if information requested is provided; beratement and belittlement; repeated attempts at inducing guilt; all mixed in with ideological utterances.[3,4] To resist this type of duress, the prisoner needs some prior knowledge, firm resolve, positive motivation, great strength of personality, considerable tolerance for hardship and discomfort and great determination to defeat his tormentors. Some will be able to resist such treatment—some will not. It is unrealistic to conceive that all men can be immunized to combat hardship and torture without yielding to an enemy. Some men, in fact many men in Korea, attempted to "collaborate" even before any hardship was extended to them other than the usual POW misery with the hope that they might forestall further distress and suffering even at the expense of others. It is highly desirable that we train and lecture loyalty to our forces to the ultimate and inform them that we expect the best from them but at the same time we must retain a realistic understanding that many will fail under this pressure no matter what we demand.

PRESENT REGULATIONS

Existing regulations require that all military personnel who fall into the hands of the enemy give no more information than name, rank, and serial number. While it is understandable that this order be promulgated, some attention should be invited to the lack of realism in this directive. It should be evident from the above that it would require a true hero to resist all the forces described over an indefinite period of time if the enemy really wishes to put on pressure. This order in effect requires that all who fall into the hands of the enemy must rise to the level of heroism or face the disgrace of punishment by his own country if and when he returns and this even though he himself may well have become a prisoner through no choice, fault or lack of courage of his own. Attention should be invited to the fact that even in active combat we do not require that all men be heroes. We ask for volunteers for particularly dangerous missions; we do not engage in foolhardy or unnecessarily dangerous tactics unless the gain is in keeping with the risk; we provide special honors and decorations for those few individuals who by virtue of great dedication, courage and self sacrifice risk their lives beyond the call of duty and we then pronounce them heroes. In this POW situation, it may well develop that we are starting with a minimal requirement that all men must rise to the hero level of performance or suffer the consequence. Anyone who has faced disaster with groups of people in war or in civilian settings knows that this is a patent absurdity and an unrealistic reaction formation and wishful projection of one's own fears and further that universal heroism cannot come to pass. A more realistic revision will, therefore, at some future time probably be forced.

POST WAR REACTIONS

Schein et al.[6] in an uncompleted psychological 5 year follow up study of former prisoners of war from Korea reports that the former prisoners in retrospect considered physical survival their greatest problem; would liked to have known in advance more about the enemy, his philosophy and the true conditions of being a POW; felt that they suffered subsequent substantial physical and psychological impairment (50% complained of "nerves"); and felt that their biggest problem after repatriation was health and vocational readjustment, although the majority made adequate adjustments. Those classified as collaborators to some degree reported slightly less neuropsychiatric disabilities, tended to choose work more involved with other people, to move more times and away from their original abode, joined churches more and veterans organizations less and were less likely to have continued contacts with other repatriates. This behavior seems consistent with their tendency to become more generally involved with other people in contrast with the non-collaborator group which showed in prison camp more apathy and withdrawal.

Careful studies[7] clearly revealed that surviving prisoners of war of World War II who suffered the longest and most severe deprivations during imprisonment (i.e. Pacific Theatre American prisoners of the Japanese) experienced a significantly higher incidence of disabilities upon return to the United States. There was an excess of mortality during the first 6 years following liberation. While this was true in several categories, it was most noticeably present in tuberculosis and accidental deaths (the latter probably being related to an extension of depressive symptoms). This might be expected in view of the comparative death rates in the prison locations, e.g. 40% death rate among the prisoner group during imprisonment in the Pacific against 1.4% for those in the European Theatre and .8% for those in the Mediterranean Theatre.

Informal observations of World War II Pacific POW's over the past 15 years made by the author indicate a wide variation of adjustments. It should be borne in mind that with all POW groups, the surviving members represent a selected group over those who did not survive. Some of these men fell with the first flush of repatriation. It seemed that some felt that they had already long overextended their attempts to tolerate disappointment, hardship and frustration. Many had necessarily constructed in their fantasy during imprisonment the untrue concept that all would be perfect if one could ever just be at home again. Thus coming home he often encountered little understanding from his family and neighbors who insisted on matching their hardships of meat, butter, and gas rations, poor housing, etc. against his personal hell; occasional apologists for his captors with sufficient lack of tact to verbalize their ideas; estranged wives; his own children who didn't know him and even worse often didn't like him; a changed economy, work situation or service; the distinct material handicap of loss of pay, promotion and professional competence in comparison with his non-captured service contemporaries; physical disabilities; troublesome feelings of guilt, chronic depression, headaches, chronic fatigue and a confused self picture of being part hero, part coward, part oddity and part junior version of Rip Van Winkle. All this and more helped to produce feelings of discouragement, futility, hostility and withdrawal and frequent overuse of alcohol. Some retired to obscurity, some drank or drove to death while others were just swept along as nonentities with the stagnant mass of humanity never daring to aspire to higher goals or achievements—a much beaten dog that never recovers his feeling of the joy and verve of living. Some, for unclear reasons, were able to overcome these handicaps or perhaps met with some more fortuitous circumstances and were able to once again make a suitable adjustment and resume their place in society. Some propelled by compensatory striving probably gained more than they would if they had not been so taunted by one of life's nastier tricks. With this group as the Korean group those who were able eventually to make a satisfactory adjustment admit that the experience lent them a great ability to tolerate disappointment, frustration and human nonsense.

I would like to conclude by stating that in the future we might gauge the index of man's humanitarian growth and gain by the manner in which he is able to rise above his more basic cruel animalistic impulses as reflected in his treatment of prisoners of war.

REFERENCES

[1] Kantor, MacKinley: *Andersonville*, World Publishing Co., 1955.

[2] Nardini, J. E., Hermann, Robert S., and Rasmussen, J. E.: Navy Psychiatric Studies in the Antarctic. Presented at the 117th Annual Meeting (1961), American Psychiatric Association. In press.

[3] Nardini, J. E.: Survival Factors in American Prisoners of War of the Japanese. Amer. J. of Psychiatry, 109:241-248, Oct. 1952.

[4] Biderman, Albert D.: Death as a Criterion in the Study of Extreme Captivity Situations. Bureau of Social Science Research, Inc., Washington, D.C.

[5] Biderman, Albert D.: Communist Techniques of Coercive Interrogation: A Report. Air Force Development.

[6] Schein, Edgar H., Cosley, W. E., and Singer, Margaret T.: A Psychological Follow-up of Former Prisoners of War of the Chinese Communists. Mass. Inst. Technology.

[7] U.S. Government Publication: Effects of Malnutrition and other Hardships in the Mortality and Morbidity of Former U.S. Prisoners of War and Civilian Internees of World War II: An Appraisal of Current Information prepared by the Department of Health, Education, and Welfare in cooperation with the Veterans Administration, Department of Labor and Department of Defense, pursuant to Public Law 744, 83rd Congress, 2nd Session.

[8] Hinkle, Lawrence E., and Wolff, Harold G.: Communist Interrogation and Indoctrination of "Enemies of the State." Arch. of Neurology and Psychiatry, 76:115-174, Aug. 1956.

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March 29, 1983

The Honorable Alan K. Simpson, Chairman
United States Senate
Committee on Veterans' Affairs
Washington, D.C. 20510

Dear Senator Simpson:

This communication is in response to your letter of March 14, 1983.

I greatly appreciate the opportunity to respond belatedly to your request.

Sincerely,

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John E. Nardini, M.D.

JEN/mfm
Enclosures: 3 copies of 3 papers
Copy of Statements from DSM-III;
Dysthymic Disorders; and
Post-traumatic Stress Disorder,
Chronic or Delayed

STATEMENT ON DEPRESSION IN PRIOR PRISONERS OF WAR

The major attributes that make up a total human are (1) the physical constitution, (2) intellectual capabilities, (3) emotional composition, (4) personality, (5) character, and (6) spirituality.

Our current interest here is with number three; namely, the emotional component of man and of man in relation to his environment. Further, this case is a very special type of his environment; namely, war and prisoner of war experience.

My particular experience with prisoner of war problems consists of having served myself for five years, (five months of combat experience on Corregidor and Bataan in World War II in the Philippine Islands, and three and one-half years as a prisoner of war of the Japanese Imperial Army while a:Lieutenant in the U.S. Navy Medical Corps. Subsequent to this I worked with problems associated with Korean theatre prisoners of war in the 1950s. Later served as a national consultant in psychiatry to the Surgeons General of the U.S. Air Force and U.S. Navy during the Vietnam war and in that capacity assisted extensively in establishing the psychiatric protocols for the studies of the returned prisoners of war. Also, over the years I have known and treated a wide variety of men who had been prisoners of war in the various wars. I have consistently worked in psychiatry since 1946, both in the Navy to 1961 when I retired as a Captain, USN (MC), and since then in the private practice of psychiatry in Washington, D.C. to the present time.

A few general statements should be made regarding emotion. It may be difficult to pinpoint at exactly what point in the evolutionary scale of animal development emotion first made its appearance. We can safely say, however, it is clearly evident in our own order; namely, mammalia to which we humans belong. Fear and anger seem ubiquitous and probably protective to both the individual and the separate species. Love in its largest sense seems to be primarily the protector of the species to promote the survival of the species. The "lesser" species seem to accomplish the same process by instinct. Our primary concern here in relation to the question of depression is fear and anger. Fear is a concept much more simple and easy to comprehend than anger, and no human has ever failed to experience it. Anger is much more complex, dangerous, and destructive in both short and long range.

Since humans have the most complex central nervous system, it is not surprising that feelings such as anger present greater problems. Anger immediately felt and expressed in primitive human social situations is closer to lower animal simplicity. There is a feeling--explosive action--and rapid subsidence of feelings. In higher mentally and socially endowed humans more complex and far-reaching mechanisms develop. One of the most important mechanisms related to anger in our society is called repression, which is an unconscious, pushing-out of awareness of a feeling of anger that is appropriately induced by a situation. A perfect example of repression can be seen in the following story. Little Johnny is angry at something his mother did that he did not like. He hurled at her, "You damn son of a bitch." To most mothers these are fighting words and mother had to take action and wash his mouth out with soap and water. A few days later she did something dumb again. Johnny again came out with, "You damn son of a bitch." Again, the soap and water treatment. This went on for several episodes. Eventually Johnny became angry again when his mother did something stupid, "You damn," and stopped with this, but it was still too late and he had the soap and water treatment again. A few days later another similar episode and he came out with, "You," and stopped, no soap and water. A few times subsequent to this the same thing, but he said nothing. After a few weeks when Johnny's father came home his mother commented, "My what a wonderful boy Johnny has been today. He was so quiet, I never heard a peep out of him. He sat in the yard all day long, quietly to himself, not making any trouble." The mechanism here, of course, is one of repression where the anger was forced out of awareness and felt as depression with Johnny being quiet, inconspicuous, inactive, and depressed. It is obvious that in civilization uncontrolled anger cannot be tolerated if people are to successfully live together. Hence, the conflict; that is, immediate, natural urge to give physical vent to feelings of anger on the one hand and on the other hand awareness of the social, legal, moral, and religious implications. In the example cited above, the picture is clear. However, later in life when the same process occurs it is often obscured by many side issues, happenings, and adjustments.

A truism may be advanced that humans become angry when something is done to them they do not like or want or they do not get something they like, want, or need. It seems reasonable to assume that probably a solid majority of the people in this country fare satisfactorily socially in this regard when compared with the people in the world at large. There is also some rough measure of reasonable expectation in life in a given social setting which varies from one group to another; for example, an average youngster born in the United States versus one born as one of China's millions.

With this in mind, we are trying to look at a particular segment of human experience of Americans in war and prisoner of war status. We also have to keep in mind the question of magnitude of provocative features that engender the feelings of anger.

The prisoner of war experience is unique. While it is akin to slavery, social/political abasement of groups in recent concentration camp experience, it is still different.

The prisoner of war starts out as a free individual volunteering his life to his country with honor, is a member of an honorable and at least in wartime highly esteemed group--the military. Society and governments have held many conferences, etc. to provide humanitarian controls over those unfortunate enough to fall into the POW role. From the beginning of time to the present, the lot of the POW is a catastrophe. Admittedly, the lot varies tremendously from one place, time, season, war, and captor to another. When relief is sought for specific difficulties experienced by POWs, the question is often advanced--why should POWs have special consideration over combat soldiers? The answer to this is that (1) all POWs were combat soldiers, and (2) they had an extra undeserved dose of trauma imposed upon them. I personally experienced a hellish five months of combat on Corregidor and Bataan, as well as three and one-half years as a POW, and I would elect to take one hundred days of combat to any one day as a POW, and I suspect most POWs would elect the same. It is also significant to mention that in general it is rare for an individual to become a POW--the usual pattern is for one to surrender as one of an outnumbered group.

What, then, are the unique factors that make the POW experience such a highly traumatic experience that leaves a permanent scar on his emotional life so long as he lives? What happened to him emotionally? What factors built up anger, inner rage, repression, and deep abiding depression and its long-standing later equivalents? It is interesting to me to contemplate and contrast the Purple Heart medal truly, correctly, properly, and honorably awarded for any degree of bodily contact with enemy fire; for example, a flesh wound from a bullet, shrapnel, etc., and the often vastly more devastating maceration of the human psyche as a result of direct enemy action as a POW. We often speak of physical and emotional scars. The simile is a poor one. A wound scar consists of inactive, non-functioning scar tissue at the site of an old injury that was painful for a relatively short period of time and ceases to be a source of pain forever thereafter. On the other hand, an emotional "scar" remains viable for a lifetime. A memory is stored which is readily recalled, with or without intent, to bring back all of the original impact of this original happening or experience and all of its attending feelings in full force to be re-experienced anew over and over again. If the memory is bad, it is easy to see the wearing and ever-pounding effect of the psychic trauma. How can one "erase" the sight and memory of a buddy being beaten to a pulp; or executed by gunfire or beheaded; or the prolonged and repeated intimidating, haranguing, life-threatening, physically torturing session with a hostile captor with a terrible inner fear of "cracking" and forever feeling weak and guilty before one's peers and fellow countrymen; or the sight of 60 deceased POWs reduced to skeleton corpses being carried openly to a common grave every day as a result of total abuse and deprivation of his captors and realizing he may be next down the road, etc., etc.?

At the first meeting of the Administrators Advisory Committee on Former Prisoners of War in April 1982, I drew up a partial list of traumatic issues to which POWs were exposed. The list is as follows. There are indeed more, but this may suffice for the present purposes. The state-of-the-art in medicine at this time is such that even though the POWs experienced great physical trauma from starvation, malaria, dysentery, hypoproteinemia, scurvy, pellagra, beriberi, tuberculosis, etc. during imprisonment which may well have imposed permanent structural damage, there is no means of demonstrating the damage later except with evidence of tuberculosis, optic atrophy, and peripheral neuropathy. Therefore, the epidemiological data already in existence should be employed as it is in other civilian medical situations such as lung cancer with its relation to smoking, peripheral vascular disease in relation to birth control pills, DES (diethylstilbesterol) in relation to its past use in threatened miscarriages with subsequent damage, post-menopausal use of estrogens and its relation to uterine cancer, and excessive use of alcohol with the presumptive cause of cirrhosis of the liver. In the psychiatric sphere I believe an easier case but equally nonvisible can be made for emotional reactions of conditions regarding the aftermath effects of the psychological stress incurred during imprisonment. The stress factors are essentially: (1) the daily and continuous fate of death hanging overhead; (2) a massive, frustrating, silently enraging, heavy sense of helplessness day and night so long as the imprisonment lasts; (3) a daily sense of a gloomy future; (4) sometimes bordom and ennui; (5) chronic anger and starvation; (6) pain and disease without benefit of any decent medical help; (7) forced close confinement with others who may have objectional natures and behavior; (8) limited or no news of what is happening; (9) limited or no news from home and family; (10) worry about family; (11) the strain of continual repression and suppression of anger and hatred of one's captors; (12) lack of something to do and the lack of intellectual stimulation; (13) seeing one's friends and buddies die off; (14) solitary confinement; (15) adjustment to extremes of weather without adequate protection; (16) forced marches under alien conditions; (17) exposure to aggressive attacks from one's own forces since the POW is behind the lines and often unmarked, for example, submarine air attacks producing the "hell ships" in the Philippines; (18) activities such as the massacre at Malmedy and Palowan and the Japanese experimental stations in Harbin, China where bacteriological and other experimental techniques were perpetuated against Chinese and American POWs and others totaling 3,000 deaths; (19) the sometimes distressingly painful sense of loss of personal identity; (20) painful depression and often felt as such; (21) forced labor even when sick and ailing; (22) physical disease; (23) unprovoked beatings and abuse; (24) harassment from captors in burning incoming mail in sight of the POWs and the captors pilfering Red Cross packages and food; (25) threatening speeches and threats as well as beatings from the captors; (26) brainwashing attempts; (27) torture; (28) knowledge and witnessing of executions. It is to me inconceivable how anyone could have any difficulty in comprehending that normal human beings could escape permanent damage when exposed to this experience. The imprint of these feelings lies stored deep within the cranium out of sight or even unsuspected or denied by the casual observer. The victim himself contributes to this by intentionally or otherwise concealing from himself as well as others many of his strong feelings and takes on a socially acceptable facade pretty much out of necessity. Much could be said on how the effects of these imprints affect later feelings and behavior of the surviving ex-POW and how it influences the subsequent quality of his work, life, and family. We know that suicide, accidental deaths, and alcoholism have been clear concomitants and that many aspects of psychoneuroses have been recognized to be presented in ex-POWs. The group of depressions, I suspect, have been by far the most prevalent and unrecognized set of symptoms and disabling conditions. The likelihood of this being picked up is not great unless the most sophisticated approach is employed. I think it is self-evident in viewing this magnitude of events to which this group of men have been exposed, that it is not possible to see how massive anger and resentment would fail to have been built up over a long period, both during and after imprisonment.

How, then, does this relate to depression as we understand it today? Depression is both a feeling and a state. Every person, child and adult, has experienced feelings of depression. Most feelings of depression are of short duration and dissipate spontaneously. These are referred to as reactive depressions from mild to severe and are usually related to minor and more superficial life events and invariably disappointments, failures, deprivation, aims, rejections, etc. These feelings of depression are in the psychologic sphere and have no physiological base as yet, that is no changes occur within the body or brain of any lasting nature. This is in contrast to what is referred to as endogenous depression which is believed to be associated with actual biochemical and/or neurologic changes within the brain that maintain feelings of depression even when the primary source may no longer be present. Depression, as such, is characterized by feelings of gloom; pessimism; loss of interest; loss of zest; slowing of movement and activity; slowing of thinking; loss of humor; interference with sleep and appetite; withdrawal; suicidal feelings, thoughts or actions; and poor feelings of self-worth and sometimes delusional thinking. There are many physical and constitutional reasons for depression. A common one is related to endocrine changes or disturbances; for example, thyroid deficiency and postpartum depressions. Others include postoperative conditions, postinfluensal, and postinjury. These, of course, not being specifically related to the psychologic reactive factors as described above. However, it is a highly significant fact that reactive factors, if severe enough and prolonged enough, can eventually lead into and develop into a full endogenous or physiologic depression. This is not the place to go into the matter in full, but in essence there are specific areas within the brain that control and influence mood. When these areas are not functioning normally due to very complex biochemical processes, the mood of depression with all its attending symptoms will be present. Prolonged reactive depression features that are unabated, as in POW experiences, can cause this biologic deficiency and hence lead into an endogenous depression. Furthermore, as described above, a relation to the emotionally traumatic episodes--even the bad memory can continue to do the same damage that the initial event triggered.

It is also patently obvious that each individual will have different degrees of defenses and modes of dealing with emotionally traumatic events so that his response will vary considerably. Also, some individuals are by constitution and personality more or less given to depressive reactions and conditions. Also, the degree of emotional trauma will vary from one to another. However, in the most general terms the exposure of POW experiences for any period of time is certain to generate intense feelings of anger, resentment, and frustration, etc., which will attempt to be handled by repression but cannot escape depression. There is no doubt in my mind that former POWs in comparison to other people have a much higher incidence of depressive neurosis. Further, there is no doubt that this increase is clearly and positively the direct and full result of their internment.

I have enclosed a copy of the description of the posttraumatic stress disorder from the Diagnostic and Statistical Manual of Mental Disorders, 3d edition, of the American Psychiatric Association. There will be few former POWs who have not experienced most or all of the symptoms described of this condition. Many will have experienced much worse to the point of disability and death. A highly significant increased incidence of death by suicide and accidental death was reported in the five-year follow-up in the World War II Asiatic theater POWs after return to the United States by the National Academy of Sciences. Also, I know that some of the deaths recorded as accidental were not accidental. This figure is measured against returned non-POW veterans from the same theater matched by age, assignment, rank, and status who also returned to the U.S. It is also noted that the calculated incidence of suicide in the returned Vietnam group as compared to the national suicide averages was many times higher than the national incidence of death by suicide. The VA figures themselves clearly indicate a higher incidence of psychiatric disorders in the POW group from all theatres over and above many POW groups in these theatres.

In response to the three questions directed to me listed below, I have prepared succinct statements that are supported more fully in the previously discussed material.

1. In your experience, or to your knowledge, does depressive neurosis occur more frequently in former POWs than in similar people who were not POWs?

A. There is not the slightest doubt in my mind that this is the case. This is clearly brought out by the VA statistics.

2. Is any increased incidence or prevalence of depressive neurosis in POWs a result of their internment, in your judgment?

A. In my opinion unequivocally yes.

3. Is psychiatric diagnosis sufficiently precise to distinguish between depressive neurosis and Post-Traumatic Stress Disorder with associated depressive symptoms? Would this be a useful distinction for therapeutic purposes?

A. These two described conditions have in common the usual symptoms of depression as described earlier in this report. The major difference implied is that the depressive neurosis might be considered to have had an earlier origin in life with much less clear reasons for the development of the depression where the Post Traumatic Stress Disorder is considered to have a more specific recognizable temporal episode or period of distinct heavy stressful trauma from which one might readily expect symptoms to develop. While an ex-POW might develop either condition, the most likely would be related to the Post Traumatic Stress Disorder. I have attached the descriptions of these two conditions from the Diagnostic Nomenclature of Mental Disorders (DSM-III). There is no doubt that symptoms of depression are part of Post Traumatic Stress Disorder.

I am sorry that I did not have an opportunity to meet personally with the committee at its scheduled session due to my illness. I will remain at your disposal for further consultation at any time in the future.

TEAR SHEET FROM
UNITED STATES

NAVAL
MEDICAL
BULLETIN

BUREAU OF MEDICINE AND SURGERY
NAVY DEPARTMENT

VITAMIN-DEFICIENCY DISEASES IN ALLIED PRISONERS OF THE JAPANESE

JOHN E. NARDINI
Commander (MC) U. S. N.

The writer observed at first hand the rise and fall of dietary fortunes of allied prisoners of war of the Japanese for a period of 3½ years. During this time the majority of known clinical manifestations of the deficiency diseases were observed and treated.

Symptoms varied from the mild dysthesias of beri beri to rapid dramatic death from pellagra. While the deficiency-disease symptoms were ubiquitous and sometimes fatal, it is obvious that the human metabolism can stand a lot of deficiency.

The question of vitamin deficiency developing in a normal person on anything approaching an average American diet now seems ridiculous.

An accurate description of the prisoners' diet would be lengthy since it varied from time to time and place to place. But the general daily diet included about 500 grams of rice, 500 cc. of thin soup of a current vegetable such as squash, sweet potato, onion, bean, corn, turnip, or greens. Meat varied from none for months at a time, to a daily issue of 40 or 50 grams, also for months. Fat was received in amounts only sufficient to flavor the "soup." Salt ($NaCl$) was available in small amounts about 60 percent of the time. Fruits were obtained in meager amounts in the Philippines. In Japan one man would average about two oranges, one apple, and pear in a year.

The diseases encountered were beri beri, pellagra, xerophthalmia, chelosis, and rarely scurvy.

BERI BERI

It can be safely said that 90 percent of the prisoners had some degree of beri beri at some time during their internment. The most common and least troublesome symptom was a numbness and hyperesthesia of the anterior aspect of the lower extremities. This was often not noticeable to the man unless called to his attention by pricking with a pin. This loss of sensitivity to pain in its extreme form included both upper and lower extremities, abdomen, and face.

One of the most common and miserable complaints, of perhaps doubtful origin but probable B_1 deficiency, was "painful feet" or "electric feet." These patients complained of sporadic, sharp, lancinating, sensually painful twinges in various parts of the feet (metatarsophalangeal joint regions, metatarsals), inner or outer side of the ankles, and occasionally in the lower leg, hands, or lower arms, accompanied by hyperhidrosis, and distressing burning sensation and hyperesthesia of the skin of the feet. And as these symptoms seemed to be most noticeable at nighttime there was considerable insomnia and subsequent emotional imbalance and distress, which created a vicious cycle, as this emotional disturbance accentuated the subjective symptoms described before. These men developed a characteristic gait, toes pointed outward and each foot carefully lifted up and gingerly set down again, somewhat as though walking on hot rocks. A continuation of this condition often led to a definite ataxia of lower extremities, with a gradually widened gait.

The burning sensation indirectly cost the lives of some and the toes of many more. In vain effort to obtain relief from the distressing sensation of burning feet men would even on the coldest nights in Japan keep their feet out in the cold, soak them in cold water or walk the cold concrete floors. The cold and exposure plus possible vasomotor disturbances combined to produce gangrene of the extremities and eventual loss of toes and parts of feet. A few men with beri beri incarcerated in camp jails for minor offenses suffered similar catastrophes. To the best of my knowledge none of the men in the Tropics with the same complaint of "painful feet" ever developed gangrene and loss of digits at the same time. Ill-advised lumbar sympathectomies performed by unqualified Japanese medical officers against the will of patient and prisoner doctor caused the life of several more of these unfortunate men.

One of the most insidious and disastrous conditions was the development of an optic neuritis which often advanced to atrophy in the absence of treatment or if treatment was instituted too late. Hundreds of men lost vision down to 2/200 in one or both eyes while hundreds more developed varying degrees of lesser defects. Central visual field examinations showed the greatest loss of vision when the macular area was involved. In some cases when the macula was not involved there were only varying sized scotomata. About half of the men with optic neuritis experienced no subjective symptoms along with the failing vision; the other half complained of headaches, pain "behind the eyes," burning of the eyes, difficulty in focusing and judging distance, and rapid fatigue in reading. A small number of eyegrounds examined showed typical redness and haziness of disc margins in active or earlier cases, and disc pallor (especially temporal side) in advanced atrophic cases. The onset was in some cases sudden (24 to 48 hours); in others protracted, taking weeks or months to develop. Therapy was irregular and rarely adequate and consisted of from 1 to 50 mg. of thiamine hydrochloride daily depending upon availability of the drug. Treatment in some early cases arrested or improved visual defects. When atrophy developed therapy was ineffective. Two patients with optic atrophy, dysthesias of upper and lower extremities and fifth cranial nerves, and ataxia, also developed partial bilateral deafness presumably due to eighth nerve involvement from B_1 deficiency.

Wet beri beri was extremely common. Symptoms varied from mild recurrent dependent edema to dyspnea, weakness, cardiac collapse, and death. The nature of individual edema was difficult to assess in view of suspected universal hypoproteinemia. No standard of criteria could be developed to differentiate the two forms. Some edemas responded to extra protein in the form of rare (quantitative not qualitative) Red Cross corned beef (4 ounces daily) while others responded to daily thiamine hydrochloride 3 to 5 mg. orally or parenterally. Since the two conditions were usually coexistent, no mistake could be made in the treatment. However, the picture was sometimes confused by the appearance of an occasional nephritis.

Men with borderline beri beri who developed either localized or systemic infection (such as "cold," influenza, pleurisy, pneumonia) commonly experienced a disturbance of water balance resulting in a noticeable edema. Muscular weakness, cramplike pains, and tenderness of the gastrocnemius and soleus muscles were common. This, along with other subjective symptoms, often seemed to appear in the wake of receding edema.

Regarding cardiac complaints, there were frequent nocturnal attacks of alarming shortness of breath. Those who awoke gasping were perhaps fortunate; a good number died in their sleep. Most of those who died suddenly of right-sided heart failure showed the typical post-mortem doll's head cyanosis. Nursing care was wholly inadequate and it was impossible to have men sleep sitting up. Some men with considerable cardiac weakness never reported for treatment (which was often psychotherapeutic only) while others were forced to work although gravely ill. It is not hard to understand how men returned from work and happily died before having to go out to work again the next day.

Precordial "psuedo-angina" was a frequent complaint and about half the time related to what subsequently proved to be serious cardiac weakness. The principal cardiac complaints were edema, shortness of breath, weakness, and occasional stabs of precordial pain unrelated to effort. The main physical findings of beri-beri heart disease were dependent edema, accentuated pulmonic second sound, and sometimes left heart border enlargement to percussion. Also noticed were palpitation, bradycardia followed by tachycardia when failure developed, cardiac irregularities which usually had grave prognostic significance, ascites, and crude evidence of increased venous pressure.

Roughly 75 percent of those with cardiovascular complaints had concurrent neurologic complaints or findings. A minority complained of or showed only cardiovascular symptoms. As a rule there were no cardiac stimulants and almost never enough B_1. Rest when obtainable was the best treatment that could be given. Some recovered spontaneously and some with small amounts of B_1 (1 to 3 mg. daily). Many died.

PELLAGRA

The "Four Horsemen" rode abreast of the famed four D's of pellagra—diarrhea, dermatitis, dementia, and death. From June to December 1942 at the Military Prison Camp at Cabanatuan, P. I., from 30 to 50 men were dying daily from untreated malaria including cerebral form and terminal bacillary and/or amebic dysentery, and starvation. During this period manifestations of pellagra first appeared. In view of the concurrent dysentery and malaria it was sometimes difficult to separate the symptoms of pellagra. A certain number of afebrile patients showing typical skin lesions of pellagra became demented and within several hours lapsed into coma and died. These appeared to be pellagra deaths.

It was impossible to include diarrhea as a deficiency sign in the presence of such widespread bacterial or protozoan dysentery.

The dermatitis on the other hand was clearly and easily recognized. In the Tropics vesiculation followed by superficial ulceration of the extensor surfaces of the lower arms and legs was a little less frequent than the wide, dusky red discoloration or brighter red petechialike figures in the same extensor areas. In temperate zones, there seemed to be a more discreet, superficial, circular reddish-blue lesion from 5 to 10 mm. in diameter distributed over the dorsum of arms, hands, and wrists, and to a lesser extent over the extensor surfaces of the lower legs. These lesions would sometimes ulcerate and heal only after a period of many weeks.

A very common and bothersome complaint was a painful glossitis and stomatitis, which occurred with or without skin lesions. Even bland boiled rice caused pain in eating and was difficult to masticate and swallow. Smoking and the use of condiments, if available, were out of the question. The tongue, buccal mucosa, and lips became extremely tender, red, and swollen in severe cases. Lesser degrees involved tongue and/or buccal mucosa only. As a rule the sides and tip of the tongue were earliest involved and most painful.

Sometimes associated with glossitis or other pellagric skin manifestations but more often alone, was a common and bizarre scrotal complaint. Attention was first called to the condition by an uneasy, burning sensation in the most dependent portion of the scrotum. Examination revealed only a pink or red discoloration of the lower scrotum at first. Widespread development soon ruled out strong soap as a suspected cause. If untreated, a large portion of the skin of the scrotum became discolored, edematous, scaly, and weeping. In men with severe edema from other causes, this scrotitis became serious as a weeping painful secondarily infected lesion.

The skin lesions, glossitis, and scrotitis described responded very well to nicotinic acid when available. The usual oral dose was 100 mg. daily for 10 days.

VITAMIN A DEFICIENCY

Xerophthalmia.—A large number of men had external eye complaints. Early subjective complaint consisted of photophobia, tearing, and burning. Early objective findings consisted only of slight circumcorneal injection, and some palpebral redness. Later, pain, tearing, and photophobia became more intense, and circumcorneal injection increased eventually to diffuse redness of the sclera and the ocular and palpebral conjunctiva. Some blurring of vision was complained of early but was due to nonpurulent ocular discharge. As the condition advanced a 2 to 5 mm. circular, whitish, opaque area developed on some portion of the cornea, usually so placed that all or some portion of the pupil area was covered. Vision was accordingly reduced. Some superficial corneal ulcers appeared with minimal signs and symptoms and developed almost before either doctor or patient was aware of them. These shallow ulcers tended to heal faster and leave less occlusive scars than the ulcers that developed as a whitish placque with more pronounced symptoms.

A few men developed a panophthalmitis and had the eye surgically removed. Many men had marked loss of vision from occlusive scars over the pupil.

Treatment was inadequate and irregular, and varied from nothing to ½ ounce of cod-liver oil daily. Later, when cases were rare, concentrated vitamin A and D capsules containing 5,000 units of vitamin A were used with success.

An unusual and unexplained phenomenon accounted for from 80 to 90 percent of these corneal ulcers appearing on the left eye.

Other vitamin A deficiencies included night blindness, which was difficult to evaluate, and hyperkeratosis.

SCURVY

Distinctive clinical signs and symptoms of scurvy were surprisingly infrequent. It was not possible to separate the sallow complexion of scurvy from chronic recurrent malaria with severe secondary anemia. A number of cases of subperiostial, pretibial hemorrhages were at first mistaken and incised for abscesses. These lesions (4 to 6 cm. in diameter) were painful, fluctuant, and sometimes hot. If left alone they usually were absorbed spontaneously. A number of painful intramuscular hemorrhages in the adductor muscles of the thigh and calf muscles were observed. These, too, usually disappeared if put at rest and left alone. A few became sterile abscesses and responded to incision and drainage. Healing was painful and slow. An occasional, suddenly painful hip, knee, or shoulder joint suggested hemorrhage into the joint space. If death did not intervene, pain continued for days before subsiding. Infrequent nose bleeds, subconjunctival hemorrhages, and ecchymosis were seen. Recession of gums was common and possibly of deficiency origin.

Treatment was effective when citrus fruits became available. Scurvy was undoubtedly a contributory cause of many deaths.

RIBOFLAVIN DEFICIENCY

A fairly frequent superficial erosion or ulceration of the corners of the mouth developed but was never serious or extensive. It was most often seen alone but sometimes associated with a superficial, dry, scaly, erythematous lesion spreading out from the alae of the nose to the cheeks giving the patient a particularly pinched and wizened appearance. The lesion responded to improved food.

MISCELLANEOUS

Several unclassified complaints presented themselves for clinical recognition and treatment. There were frequent outbreaks of boils; carbuncles; deep abscesses of fingers, sole and palm; and multiple superficial axillary abscesses.

One of the most intriguing complaints in the Philippines was the appearance of breast tumors. Men gradually developed these tender, hard, freely movable, discreet, 1 to 2 cm. masses on one or both breasts after 5 or 6 months of imprisonment. They were located immediately below or slightly to one side of the nipple. No significant clinical or historical features atended these cases. Surgical excision was resorted to in a few early cases before the nature of the condition was recognized. At one time there was perhaps a 5 to 6 percent incidence. Most tumors persisted for months; many gradually disappeared with improvement in food.

It is significant to note that there was frequently a direct relationship between chronic diarrhea (from amebic and/or bacillary dysentery) and avitaminosis. Men with more normal gastro-intestinal function developed fewer and milder vitamin deficiencies.

The favorite Japanese custom of frequent searching and confiscation of suspicious papers which included medical notes has made it impossible to present this material in a statistical form. Detailed notes of these observations unhappily lent greater intensity to the brilliant flames of burning Osaka.

CURRICULUM VITAE

JOHN EDWARD NARDINI, M.D., P.C.

Home Address: 5921 Bradley Boulevard
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Born: May 4, 1912, Philadelphia, Pennsylvania

Married: Helen D. Prevail

Children: Brian b 4/29/41
Kathleen b 2/27/50
Helen b 5/09/51

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Washington, D.C. 20037

EDUCATION

Northeast High School, Philadelphia, Pa. 1926-30

College of Liberal Arts and Sciences, Temple University, Philadelphia, Pa., 1930-34 - Degree - Bachelor of Science

School of Medicine, Temple University, Philadelphia, Pa., 1934-38 Degree - Doctor of Medicine

College of Physicians and Surgeons, Neurological Institute, Columbia University, New York, New York, 1951-52 - Clinical Fellowship in Neurology

MILITARY AND PROFESSIONAL EXPERIENCE

July 1938	Appointed Acting Assistant Surgeon with rank of Lieutenant (junior grade), Medical Corps, U.S. Navy
1938-1939	Rotating Internship, U.S. Naval Hospital, Philadelphia, Pa.
Aug 1939	Appointed and Commissioned Assistant Surgeon with rank of Lieutenant (junior grade), Medical Corps, Regular U.S. Navy
Sept 1939 Oct 1940	Division Medical Officer, Destroyer Division 59, Asiatic Fleet, U.S. Navy, Manila, Philippine Islands
Oct 1940 Nov 1941	First Battalion Medical Officer, Regimental Hospital, 4th U.S. Marine Regiment, Shanghai, China
Nov 1941 Apr 1942	First Battalion Medical Officer, 4th Regiment, U.S. Marine Corps, Philippine Islands (Bataan and Corregidor (WW II)
Dec 1941	Promoted to Lieutenant, Medical Corps, U.S. Navy
Apr 1942 Sept 1945	Prisoner of War of Japanese (Cabanatuan, Philippine Islands and Osaka, Akenobe, Honshu, Japan) (Medical Officer in various camps)

1946	Promoted to Lieutenant Commander, Medical Corps, United States Navy
1946	Promoted to Commander, Medical Corps, United States Navy
June 1946 July 1947	Executive Officer, United States Naval Medical Unit, United States Public Health Service Hospital, Fort Worth, Texas
July 1947 Aug 1950	Officer-in-Charge, Sick Officers Quarters, Neuropsychiatric Service, United States Naval Hospital, National Naval Medical Center, Bethesda, Maryland
Aug 1950 Aug 1951	Resident in Neurology, United States Naval Hospital, National Naval Medical Center, Bethesda, Maryland
Sept 1951 Sept 1952	Fellowship in Neurology, Columbia University, College of Physicians and Surgeons, Neurological Institute, New York City
Oct 1952 June 1953	Chief of Neuropsychiatric Service, United States Naval Hospital, Chelsea, Massachusetts
July 1953 July 1954	Chief of Neuropsychiatric Service, United States Naval Hospital, San Diego, California
July 1954 Dec 1958	Chief of Neuropsychiatric Service, United States Naval Hospital, National Naval Medical Center, Bethesda, Maryland
Jan 1955 Sept 1955	Acting Head, Neuropsychiatric Branch, Bureau of Medicine and Surgery, Department of the Navy, Washington, D.C.
Jan 1955	Promoted to Captain, Medical Corps, United States Navy
Dec 1958 Aug 1961	Head, Neuropsychiatric Branch, Bureau of Medicine and Surgery, Department of the Navy, Washington, D.C.
Aug 1961	Retired from Active Duty as Captain, Medical Corps, United States Navy. Entered Private Practice, Washington, D.C.

MILITARY DECORATIONS AND CITATIONS

Silver Star

Secretary of Navy Commendation Medal

Distinguished Unit Citation with Oak Leaf (4th Regiment, United States Marine Corps)

Pacific Theatre Ribbon with One Star

World War II Victory Medal

MILITARY DECORATIONS AND CITATIONS (Continued)

American Defense Medal with Star

Philippine Defense Ribbon with Star

National Defense Medal

Presidential Unit Citation Badge, Philippine Republic

OTHER AWARDS

Certificate of Merit, Surgeon General, United States Navy, 1961

Certificate of Appreciation, American Board of Psychiatry and Neurology
for serving 15 years as Assistant Examiner, 1966

Certificate of Commendation, American Psychiatric Association
for serving as Chairman of Committee on National Defense, 1961-62

Certificate of Commendation, American Psychiatric Association
for serving as Trustee, 1970-74

Vicennial Silver Medal
Georgetown University Medical School, 1974

BOARDS AND LICENSES

Diplomate, American Board of Psychiatry and Neurology
(Certified in Psychiatry and Neurology - December , 1952)

Diplomate, National Board of Medical Examiners, 1939

Licensed in Medicine and Surgery, M.D., Commonwealth of Pennsylvania, 1952

Licensed in Medicine and Surgery, M.D., Commonwealth of Virginia, 1955

Licensed in Medicine and Surgery, M.D., State of Maryland, 1955

Licensed in Medicine and Surgery, M.D., District of Columbia, 1961

SOCIETIES AND ORGANIZATIONS

Member, American Medical Association

Fellow, American Psychiatric Association
(Member, Committee on National Defense, 1957-61)
(Chairman, Committee on National Defense, 1961-62)
(Member, Liaison Committee for Stroke Facilities, 1969-77)
(Elected Trustee, Area III, Board of Trustees, American Psychiatric Association, 1970-71, Re-Elected 1971-74)
(Life Fellow, 1979)

SOCIETIES AND ORGANIZATIONS (Continued)

Member, Washington Psychiatric Society
(Council, 1959-61, 1965-69, 1970-71)
(Delegate to Assembly of District Branches, 1966-69)
(President, 1969-70)

Member, Association of Military Surgeons

Fellow, Association for Advancement of Science

Member, Association for Research in Nervous and Mental Diseases

Member, American Epilepsy Society

Fellow, The American Society of Physician Analysts (formerly- Eastern Psychoanalytic Society)(Member, Executive Council, 1971-73)

Fellow, American College of Psychiatrists

Member, District of Columbia Medical Society

Member, American Neurological Association

Member, Group for the Advancement of Psychiatry, 1958 to present
(Consultant to Committee on Governmental Agencies, 1955-58)
(Member, Committee on Governmental Agencies, 1958 to present)
(Chairman, Committee on Governmental Agencies, 1960-63)
(Contributing Member, 1975 to present)

Member, International Psychiatric Association for the Advancement of Electrotherapy (1st Vice President and President-Elect, 1979)
President, 1980

Fellow, Pan American Medical Association

Fellow, The Royal Society of Medicine (Great Britain)

Fellow, The Royal Society of Health (Great Britain)

Member, SAR (Sons of the American Revolution)

TEACHING

Southwestern Medical College, Dallas, Texas
Instructor in Psychiatry, 1946-47

Naval Medical School, National Naval Medical Center, Bethesda, Maryland
Instructor in Psychiatry, 1947-51

Georgetown University Medical School, Washington, D.C.
Instructor in Psychiatry, 1950-54
Clinical Assistant Professor of Psychiatry, 1954-63
Clinical Associate Professor of Psychiatry, 1963 to present
Vicennial Silver Medal, Awarded 1974

MISCELLANEOUS

Director, Loudoun County Guidance Center, Leesburg, Virginia, 1955-62

Assistant Examiner, American Board of Psychiatry and Neurology, 1954-70

Member, National Advisory Council on Neurological Diseases and Blindness, National Institutes of Health, Bethesda, Maryland, 1954-56

Member, Mental Health Study Section, National Institute of Mental Health, National Institutes of Health, Bethesda, Maryland, 1954-56

National Children's Rehabilitation Center, Lessburg, Virginia
    Consultant in Psychiatry, 1959-68
    Medical Director, 1968 to present
    Board of Directors, Vice-President and Secretary, 1968 to present

Consultant to the President's Committee on Employment of the Physically Handicapped, 1960-61

Member, Board of Directors and Physicians Advisory Board of Epilepsy Foundation of America, 1967-76
    Secretary, Epilepsy Foundation of America, 1970-76

Member, Secretary of Department of Health, Education and Welfare Committee on Transfer of St. Elizabeth's Hospital, Washington, D.C., 1970

Psychiatric Consultant to United States Information Agency, 1961 to present

Psychiatric Consultant to National Aeronautics and Space Administration, 1962 to present

Psychiatric Consultant to the Bureau of Hearing and Appeals, Social Security Agency, Department of Health, Education and Welfare, 1963 to present

Psychiatric Consultant to Agency for International Development, 1973 to present

National Consultant in Psychiatry to the Surgeon General, United States Air Force, 1971 to present

National Consultant in Psychiatry to the Surgeon General, United States Navy, 1974 to present

Deputy Chief, Department of Psychiatry, Sibley Memorial Hospital, 1963-72

Board of Directors, Psychiatric Institute, Washington, D.C., 1968 to present

Chief of Attending Services, Unit Director of Attending Unit, Psychiatric Institute of Washington, Washington, D.C., 1972-79

President, Medical Staff, Psychiatric Institute of Washington, Washington, D.C. July 16, 1979 to present

MISCELLANEOUS (Continued)

Member, Board of Directors, Groome Clinic, Washington, D.C., 1970 to present
President, Board of Directors, 1970-72

Advisory Board, Potomac Foundation for Mental Health, 1970-77

Who's Who in East and South

Member of Advisory Committee on Former Prisoners of Was to Administrator of Veterans Affairs

PUBLICATIONS

Vitamin Deficiency Diseases in Allied Prisoners of the Japanese
Naval Medical Bulletin - Mar-Apr 1947 pp 272-278

Survival Factors in American Prisoners of Was of the Japanese
American Journal of Psychiatry, Vol. 109, No. 4, Oct 1952 pp 241-248
(Delivered at the 108th Annual Meeting of the American Psychiatric Association held in Atlantic City, New Jersey, May 1952)

A Comparison of Provocative Agents in Epilepsy and Controls
(with R. Cohn and W. Boswell) Neurology, Nov-Dec 1952, Vol. 2, No. 6

The Challenging Art of Psychotherapy
(with W. Jones) United States Armed Forces Medical Journal
Vol. VI, No. 6, Jun 1955 pp 823-833)

The Correlation of Bilateral Occipital Slow Activity in the Human EEG with Certain Disorders of Behavior (with R. Cohn)
American Journal of Psychiatry, Vol. 115, No. 1, Jul 1958 pp 44-45

Problems of a One-Day-A-Week Mental Health Clinic in A Rurual Community
Virginia Medical Monthly, Vol. 84, No. 4, Apr 1957 pp 202-203

Psychiatric Concepts of Prisoners of War Confinement
Military Medicine, Vol. 127, No. 4, Apr 1962 (Delivered as The William C. Porter Lecture-1961 at the 68th Annual Meeting of the Association of Military Surgeons of the United States held in Washington, D.C., November 7, 1961)

Navy Psychiatric Assessment Program in the Antarctic
(with CDR R.S. Herrman, MSC, USN and CDR J.E. Rasmussen, MSC, USN)
American Journal of Psychiatry, Vol. 119, No. 2, Aug 1962
(Delivered at the 117th Annual Meeting of the American Psychiatric Association held in Chicago, Illinois, May 1961)

Narcotic Addiction
Current Therapy, 1963 pp 525-526

Careers in General Practice of Psychotherapy
Career Directions, Vol. III, No. 5, 1973 pp 34-46

TESTIMONY OF THEODORE E. WOODWARD, M.D., DSC. (HON), M.A.C.P.

It has been my privilege to serve on the Chief Veterans Administrator's Advisory Committee on Former Prisoners of War since its inception in 1982. I am not a former POW but rather a five year veteran of World War II who served overseas for forty-eight months. This experience provided opportunities to cope with persons who suffered privation, misery and malnutrition. Among them were American and Philippine civilian POWs who were incarcerated in Manila and elsewhere.

After these many years following the war, when invited to serve on this Committee, I was unsure of the magnitude of the problem or intent of the evaluation process. After the war, I served as a medical school professor and chairman of medicine, helped teach young men and women to become physicians, performed some respectable medical research and made house calls.

There are three physicians on the Advisory Committee who are not former prisoners of war in addition to Dr. Nardini. Altogether seven physicians served on the Committee which had the further advantage of consultation with numerous consulting scientists. The Committee comprises able, intelligent, objective and serious minded, former prisoners of war and dedicated Americans. They taught us much about the details of deprivation, the interminable periods of despair, fear, of the impact upon them and the unquestioned obligation now to make reasonable and fair restitution to those who merit it. After careful evaluation of the medical, ethical, social and psychological considerations, the non-POW physician members of the Advisory Committee formulated the following summary resolution, fully endorsed by the entire Committee:

"Medical members of the Advisory Committee who have extensively studied the POW medical illnesses and their aftermath unanimously endorse the following recommendations and are of the opinion that they represent a medical consensus. These Committee members represent a wide spectrum of medical specialties including the fields of internal medicine, nutrition and epidemiology, gerontology, cardiology, psychiatry and neurology. They addressed in depth the conditions of living during imprisonment, the diseases experienced and endured, the lack of treatment and the long aftermath years. They reviewed many diverse papers and studies. It was noted that the POWs in World War II and the Korean War suffered a 40 percent death rate during imprisonment. The survivors were exposed to and experienced the same conditions of starvation, disease, deprivation and lack of treatment. It was noted that the POW survivors of World War II Asian theater and the Vietnam War had a suicide rate many times higher than the general population.

It is the opinion of the members that the Veterans Administration should be permitted through congressional action to accept as sufficient evidence of service connection the findings and analysis of reliable epidemiologic and medical data including psychologic considerations involving former POWs and the generally accepted medical literature on conditions prevalent among former POWs.

Additionally, published medical evidence available is more than sufficient for award of compensation relative to a number of disorders. The former POWs who have been demonstrably exposed to excessive and prolonged stress and deprivation should be presumed service-connected for the following diagnosed conditions:

(1) Cardiovascular conditions leading to aterioslerotic heart disease, hypertension and cardiomyopathies with such consequences as arrhythmias and embolization.

(2) Neurological abnormalities derived from malnutrition, avitaminosis, peripheral neuropathy, similar deficiency diseases, and optic atrophy.

(3) All psychiatric and psychological disabilities including the symptoms of alcoholism resulting from often recognized chronic anxiety and depressive states.

(4) Altered susceptibility to illnesses, such as tuberculosis occuring at any time, chronic lung disease (e.g., for laboring in coal, copper or asbestos mines) and certain allergic disorders.

(5) Major hepatic disorders, such as hepatitis, chronic active hepatitis leading to cirrhosis and hepatoma; also, organic intestinal diseases, such as colitis.

(6) Peripheral vascular disease (such as frozen feet syndrome).

(7) Arthritis, such as traumatic arthritis and certain connective tissue diseases."

Some basic medical principles will be briefly reviewed with you with the understanding that in medical science everything is not black or white; sometimes it is gray. Following are some simple fundamental facts, not presented in the lofty verbage of academia but rather an attempt at understandable expression.

Stress and Illness: There is no question regarding the deleterious effects of stress on the incidence of human health and increased susceptibility to infections. Hans Selye of Canada showed this many years ago, as did Pasteur and others in the nineteenth century. Such factors as malnutrition, endocrine or metabolic imbalance, the presence of a foreign body or extremes of temperature favor more illness. Louis Pasteur showed that cold chickens die when injected with anthrax germs; warm chickens survive. Pneumonia and other lung infections are worse with low body temperature; fever in pneumonia is a favorable sign.

Malnutrition, meaning undernutrition, weakens the body defenses. Under these conditions, with body stores depleted, desired elevations of fever may not occur. Also, the malnourished body fails to develop proper antibodies to fight off illness. Nor do such persons have the proper type of blood cells, called phagocytes, which are sorely needed to engulf and destroy disease producing bacteria.

When malnutrition and dehydration are combined, which was the *daily* lot of former POWs (months on end), the body cells lose water and potassium. Potassium is an important mineral which, when at a low level, leads to weakness, irregular heart action and stoppage (cardiac arrest). Paul Cannon, a remarkable physiologist of Chicago, showed the important effects of severe malnutrition on antibody formation and the status and function of the blood and protective body cells. Infection, draining wounds, diarrhea and other illness all make malnutrition even worse. Under these conditions, wounds fail to heal, bones do not mend properly because of poor callus formation; there is marked predisposition to bleeding and hemorrhagic shock and markedly decreased ability to withstand infection. Under the extremes of malnutrition and dehydration, an acid condition, known as acidosis, develops which can have immediate and long term deleterious effects on the connective tissue. This is the matrix or foundation tissue of our bodies. Long-term effects may be joint, musculoskeletal disease and arthritis. Constant diarrhea in combination with malnutrition leads to poor intestinal absorption (malabsorption). Lining cells of the intestine, called villi, become flat. Under these conditions, vitamins and nutrients are not well absorbed. There may be no long-term recovery when such conditions exist over a long period.

Anxiety and fear will have profound effects on anyone. Under such conditions, stomach secretions increase and ulcers frequently occur. This type of hyperactivity often leads to increased motility of the intestine (known as irritable bowel syndrome). Patients with severe burns develop stomach ulcers, a fact which confirms the relationship of stress and related gastrointestinal complications. Riach, a prominent neurophysiologist, vividly demonstrated the relationship of anxiety-tension and the development of stomach ulcer in primates.

There are many contemporary stress factors such as radiation, hormonal imbalance (such as steroids) and alcohol. Combine any one of these with malnutrition and the result is even a more unfavorable balance of body functions. There is no question that malnutrition alone unfavorably effects the function of four body systems: (1) the nervous system, either the brain or peripheral nerves; (2) the body's response to infection (unfavorable effect upon the inflammatory reaction); (3) the hepatic system (liver); and (4) the muscular system either skeletal or heart muscle. There is scientific evidence for all of these unfavorable influences of malnutrition and health. In significantly malnourished persons, the addition of little alcohol (well below an accepted norm), or steroid imbalance or radiation effect can all lead to damage of the liver, brain or other body systems. A malnourished person who develops diarrhea or a relatively simple illness like measles or chickenpox becomes even more malnourished. With it comes a carousel of ill effects.

The aforementioned are all accepted scientific facts. Many former POWs could not fight off or resist these adverse effects. They simply died while imprisoned. Those who survived did so because of a stronger consititution, a stronger will to survive such depriviation and other unknown factors. It is to this group that we now briefly direct attention.

LONG TERM EFFECTS OF UNDERNUTRITION, AVITAMINOSIS AND MINERAL DEPLETION

A number of matters are not fully clarified, yet the weight of evidence favors a long term deleterious effect on the human body.

There is no doubt about the effect of immediate abnormalities on illness and death.

There is no doubt that significant changes occur in the body tissues of the survivor.

In extreme malnutrition, muscle mass diminishes (merely look at the pictures of liberated prisoners). Glycogen (a reservoir for glucose) and amino acids drop greatly in the malnourished. These nutrients are very important for normal liver function. Hence, there is immediate injury of this vital organ and in the survivor an inability to resist other medical insult like a normal person.

There is no doubt of the adverse effects of malnutrition on the connective tissue (body matrix). These are: (1) depression of antibody (poor immune response), (2) blood cell depression (poor ability to fight infection), (3) depletion of minerals such as potassium, calcium, phosphorus, magnesium, all essential for normal body function, (4) development of acidosis which can have long-term effects including development of lung abnormalities, and (5) avitaminosis (particularly of vitamin B complex and B_1) which has immediate and lasting effects when deprivation is prolonged even for as little as six weeks.

The connective tissue is directly involved in musculoskeletal disorders and conditions such as arthritis. Vitamins, hormones and chemical enzymes are all necessary for proper balance and smooth function of the connective tissue. All of the connective tissue diseases encountered today are disorders of the immune system. Rheumatoid arthritis is a classic example. Its cause is unknown but there is absolutely no way to exclude older abnormalities (such as those mentioned) as a contributor to later development of these kinds of disabling disorders.

A striking example of an adverse long-term effect is beri beri. This is due to a deficiency of vitamin B_1. It can take the form of a large, poorly functioning heart, or a form of neuritis involving foot drop and wrist drop. In other words, the hands or the feet won't move. Proper therapy is corrective if the condition is not too far advanced and proper treatment is provided. Yet, POWs often had no treatment much less proper therapy. Who is to say that serious nerve disorders, which appeared much later, did not have their beginning at the time of the initial vitamin deprivation. Virtually ever POW under Japanese supervision developed "hot" or "electric" foot within six weeks of deprivation. This is due to a lack of vitamin B_1. A large heart which persists for weeks as a result of vitamin B_1 deficiency may well result in heart weakness for the remainder of that person's life. Such persons may die suddenly from an irregular heart action or slowly. Even at the time of death, a qualified pathologist cannot clearly define the cause as due to vitamin deficiency nor can he rule it out. Yet, beri-beri heart disease is an unquestioned medical entity. Diphtheria can have the same effects on the heart and nervous system. Its long-term effects are unchartered. Many of our POWs had diphtheria in their prison concentration camps in spite of prior immunization. They developed diphtheria simply because the malnourished patient is a sitting duck for all types of malnutrition, i.e., the immune defense is changed and his resistance is low.

Are there other examples? Is there an interaction between abnormalities of protein, mineral and vitamin depletion and arteriosclerosis of the blood vessels? There are no confirmatory or deniable data on this point, even in 1985.

With respect to debatable disability disorders of former POWs, such as arteriosclerotic conditions or rheumatoid arthritis, compensation should be allowed if: that veteran never fully regained normal health after imprisonment and he/she experienced abnormalities of the heart or vascular system (such as coronary artery sclerosis, stroke or hypertension) or the connective tissue system (such as rheumatoid arthritis) on a continuing or repetitive manner during the ensuing years.

In certain extenuating circumstances adjudication should be decided on an individual basis. Conceivably, a former POW returned to military service or civilian life and enjoyed an extended period of good health with freedom from clinical manifestations of arthritis, intestinal disorders or heart disease, including angina pectoris. After this extended period involving years of good health, gainful employment and normal social adjustment, clinical manifestations involving the aforementioned body systems may have occurred for the first time. Under these circumstances, individual consideration of all factors, the medical history and physical findings, social, emotional, demographic and epidemiological, are to be applied before a claim is denied.

Ladies and gentlemen, we are here to openly discuss an attitude about a matter for which there is no precise blueprint. The problem we share with you merits unstinting attention by everyone concerned. This includes the public which has little insight into the issues at hand.

With your indulgence, a few descriptive pictures will be shown to stress some of the points made.

THE AMERICAN LEGION,
Washington, DC, June 17, 1985.

Hon. DOUGLAS APPLEGATE,
Chairman, Subcommittee on Compensation, Pension and Insurance, Committee on Veterans Affairs, House of Representatives, Washington, DC

DEAR CHAIRMAN APPLEGATE: During its meeting of May 8-9, 1985 the National Executive Committee of The American Legion approved Resolution No. 16, which sets forth the Legion's policy on presumptive disabilities of former Prisoners of War. A copy of Resolution No. 16 is attached.

Briefly, the resolution supports the amendment of section 312 of title 38, United States Code, to provide presumptive service connection for five categories of disease or disability, in the absence of demonstrable intercurrent disease or injury. In addition, the mandate sets forth our support for the amendment of section 612(b)(1)(G) of the title, to change the period of time that a former POW must have been detained or interned in order to be eligible for outpatient dental services and treatment, from six months to thirty days.

Over the past two decades, The American Legion has supported a number of responsible legislative initiatives relative to former Prisoners of War. Most recently, we were very much involved in the development and support of the legislation that led to the enactment of Public Law 97-37, the Former Prisoners of War Benefits Act of 1981.

We bring Resolution No. 16 to your attention at this time because we understand that a hearing has been scheduled to consider legislation, H.R. 864, and to hear testimony on other issues of concern that is to be presented by former Prisoners of War.

Sincerely,
E. PHILIP RIGGIN,
Director, National Legislative Commission.

Enclosure.

NATIONAL EXECUTIVE COMMITTEE MEETING OF THE AMERICAN LEGION, MAY 8-9, 1985

Resolution No. 16.
Commission: National Veterans Affairs and Rehabilitation.
Subject: The American Legion Policy on Presumptive Disabilities of Former Prisoners of War.

Whereas, in its concern for the welfare of all those who have served in the nation's Armed Forces, one of the major concerns of The American Legion has been the welfare of those who have been Prisoners of War; and

Whereas, The American Legion has supported various legislative measures intended to alleviate the disabilities that afflict former POWs as a result of experiences during internment; and

Whereas, most recently The American Legion supported enactment of Public Law 97-37, the Former Prisoners of War Benefits Act of 1981, approved August 14, 1981; and

Whereas, there are now surviving approximately 85,000 former POWs of the four American Wars of the Twentieth Century; and

Whereas, continued observation of their condition during the years subsequent to their internment indicates additional health problems probably associated with the internment; and

Whereas, the United States has a fundamental obligation to do all possible to alleviate any and all health problems of former POWs, and see to their physical, social and economic well-being; and

Whereas, there is an apparent need to further modify the current provisions of title 38 of the United States Code that provide for former POWs; now, therefore, be it

Resolved, by the National Executive Committee of The American Legion in regular meeting assembled in Indianapolis, Indiana, May 8-9, 1985, that The American Legion shall support legislation to amend section 312 of title 38, United States Code, in such a way as to provide presumptive service connection for the following conditions in the absence of demonstrable intercurrent disease or injury:

(1) Hepatitis or other infectious diseases of the liver;

(2) Organic residuals of hypothermia, e.g., trench foot, immersion foot or hand, Raynaud's Disease;

(3) Arthritis;

(4) Peripheral neuropathy;

(5) Chronic pulmonary disease (where there is history of forced labor in mines during internment); and, be it further

Resolved, that The American Legion supports amendment of section 612(b)(1)(G) of title 38, USC, to strike out the words "six months" and insert in lieu thereof the words "thirty days,"; and, be it finally

Resolved, that The American Legion shall support any and all efforts on the part of the United States Government to alleviate and ameliorate social, economic and physical disabilities experienced by former POWs where such disabilities can reasonably be attributed to the effects of internment by the enemies of the United States.

PREPARED STATEMENT OF ALFRED P. GALLOWAY, NATIONAL COMMANDER, AMERICAN EX-PRISONERS OF WAR

Mr. Chairman and Distinguished Members of the Committee: Thank you for the opportunity to speak on this legislation so vital to the 85,000 still-living survivors of incredible brutal and harsh POW experiences. As you know, our numbers are dropping rapidly. Nearly 9,000 have died since the passage of PL 97-37 only four short years ago!

We intend to show the Committee that the proposed additions to the presumptive list contained in this bill are fully warranted and, we urge, out of humanitarian considerations, prompt and favorable action. We believe the cost will be largely offset by the elimination of the protracted adjudication procedures now typically requiring years to complete.

The Former Prisoner of War Benefits Act of 1981 (PL 97-37) was a godsend to POWs and we will remain eternally grateful to the House Veterans' Affairs Committee for its strong and compassionate support. That legislation opened up the doors of the VA health care system to many ill and desperate POWs. It also expanded the presumptive list for determination of service connection by adding anxiety states. With the subsequent addition of dysthymic disorders as a part of PL 98-223 in 1984, Congress has fully addressed the long-term psychiatric consequences of the POW experience.

However, Mr. Chairman, that legislation did *not* expand the presumptive list to include any additional long-term physical disabilities. Rather, it mandated the establishment of a POW Advisory Committee comprised of medical experts in fields pertinent to disabilities prevalent among POWs, as well as POWs representative of the various wars and divergent theaters of operation within those wars. That Committee was charged with assessing the needs of POWs with respect to possible service connection for other disabilities, and for making appropriate recommendations for administrative and legislative action.

The Advisory Committee concluded, unanimously and without reservation, in its 1983 report, that the starvation and deprivation of the POW experience was unquestionably causally related to later health problems in all major body systems! It did so after careful review of research findings and expert opinion over the 40-years that have transpired since WWII. The medical subcommittee even met with 9 consultants long known for their expertise in POW matters prior to their decision.

The Committee further noted that, despite the passage of 40 years, the POW presumptive list of physical conditions was, with the exception of helminthiasis and chronic dysentery, entirely limited to acute nutritional deficiency-related diseases and their immediate consequences. Entirely absent from the presumptive list, Mr. Chairman, are the slowly developing and delayed physical conditions so clearly anticipated by the War Crimes Commission in 1950, by Congressional hearings that same year, and by a special interagency committee appointed by President Eisenhower in 1956. They all confirmed what the VA Administrator previously stated in 1948. Here but a few quotes from those earlier assessments.

"the near-starvation diets . . . impaired their internal organs . . . in many cases in effects of such malnutrition would escape detection in ordinary physical examinations because such symptoms are not detectable . . . or show up long afterwards." (VA Administrator, 1948)

"Effects of certain dietary deficiencies may be irreversible . . . Real problems involve disabilities which are difficult or impossible to detect by objective measures or tests . . . these techniques are completely useless to evaluate . . . individuals who have suffered from active malnutrition 10 or more years previously." (President Eisenhower Committee, 1956)

Indeed, even the 1984 Revision of VA's pamphlet "Benefits for Former POWs" specifically states: "avitaminosis may affect many parts of your body and cause *delayed* disabilities."

Mr. Chairman, the POW Advisory Committee found that, despite this general recognition, when it came to individual POW claims current VA methods of determining disability and deciding service connection were totally inadequate. It understood VA's concern that the overall integrity of the adjudication system was contingent on the established policies and procedures, yet emphasized that justice and fairness to all categories of veterans must be a guiding principle. It noted that medical science has not progressed to the point of confirming a specific etiological process for relating given conditions to the deprivation and malnutrition of the POW experience. Thus, the current adjudication approach was simply not applicable to legitimate claims of POWs.

This same problem was originally present for psychiatric disorders. It was only resolved with specific additions to the presumptive list in 1981 and 1984. The Committee, for all of these reasons and more, concluded that expansion of the presumptive list to include certain physical conditions was the only viable approach for modifying an adjudication system that is simply not working for POWs.

Mr. Chairman, before providing specific evidence for each of the proposed physical conditions that would be added to the presumptive list, I would like to comment briefly on VA's reluctance to wholeheartedly support this legislation. We are frankly perplexed since VA spokesmen from 1948 to the present have agreed over and over again that malnutrition would damage body organs with delayed or slowly progressing onset. Also, virtually every involved medical expert around the world from 1950 to the present argues with reservation that the POW experience leaves such consequences.

We understand VA's concern that medical science has not yet reached the point where a precise etiological pattern can be identified tying malnutrition of this type POWs suffered many years earlier to each specific disease.

But we know—as VA must know—that such precise scientific answers will simply not be forthcoming in the lifetime of most POWs. Under these circumstances, it seems grossly unfair and unwarranted for the VA to continue to impose the following unachievable requirement:

"The VA will grant service connection . . . *when* the medical and scientific communities reach a consensus on a study which is statistically significant, has withstood peer review, can be duplicated, and which finds there is a relationship between the POW experience and the disease or disability." (VA comment to Recommendation #1, 1983 Advisory Committee Report)

As the POW Advisory Committee has also noted, the application of reasonale doubt to POW claims is meaningless since VA acknowledges it is tied to the individual *fact* situation. That means medical evidence in the POW's record. Since A ties "facts" only to what is already scientifically proven in respect to etiology, such facts simply do not exist in POW claims.

VA has also expressed a concern that undeserving veterans might benefit from modifying the adjudication process or adding to the presumptive list. We believe the response of POWs to benefits authorized by PL 97-37 demonstrates they do not take unfair advantage of such benefits. Indeed, the actual cost of adding anxiety states to the presumptive list was only one fourth of VA's estimated costs! Mr. Everett Alvarez, Deputy Administrator—and himself a POW for 8½ years—stated in a taped interview in March 1985 that POWs are creditable, they tell it like it is. And this is exactly what the record shows, POWs do not abuse or exploit their benefits.

Mr. Chairman, I would now like to present specific evidence and information in support of each of the proposed additions to the presumptive list contained in this bill.

A. CHRONIC LIVER DISEASE

The NAS mortality studies of WWII and Korean Conflict POWs published in 1980 by Robert Keehn found that, beginning with the 10th followup year, there was an excess of deaths due to cirrhosis of the liver among the POW group. This was true regardless of where they were held captive. This finding is consistent with numerous other studies as well as expert opinion in this country and throughout the world.

Liver conditions are known with scientific certainty to result from nutritional deficiencies and unsanitary conditions as were typical of the POW experience. Such damage can be irreversible. Hepatitis was virtually universal in Asiatic POWs, widespread in German camps, and untreated in both despite its life-threatening character.

Statistical data compiled by DVB from October 1, 1981 to December 1, 1984 reveals little or no favorable action on such claims of POWs. BVA data for 1983 reveals the same picture. Both DVB and BVA decisions invariably based their denials on the absence of such diagnosis in the service record and/or the fact that the cirrhosis was not manifested until many years later. They conclude it would be "speculative" to associate present liver conditions with hepatitis that occurred while a POW and add (incorrectly) that "generally accepted medical principles will not support a condition that the veterans' cirrhosis could result from known POW dietary deprivations or unsanitary conditions."

There is great resistance to obtaining outside medical specialist opinions as VA regulations provide. However, in those cases where BVA did accede to repeated requests, that opinion was always supportive of the veteran's claim or clearly establishes a reasonable doubt. For example, in 1982 the hepatologist selected by VA stated:

"There are no smoking guns for an alcoholic etiology and description of the tissue fits very well with post-neurotic or post-viral etiology . . . it is inappropriate to state he had no hepatic residuals from his jaundice while a POW." (XC 18 111 187)

On this basis, BVA finally did reverse its previous denial action.

Another example, in 1985, BVA (as DVB before it) was unchanged with respect to adjudicating policies. The hepatologist selected by VA stated: "liver disease is frequently asymptomatic early in its course and remains so for many years and only becomes symptomatic after development of end-state cirrhosis . . . the presence of a normal physical examination at the time of discharge (from service) certainly does not exclude significant ongoing liver disease . . . it would be very difficult to prove the liver disease was *not* related to possible viral hepatitis that was sustained in WWII." (XC 6 526 064)

This case has not yet been acted on by BVA but responsible medical opinion provided by the veteran was previously rejected and the Board had originally refused to seek such an expert opinion.

In both these cases, which are entirely typical of the substantive issues in POW claims, the process has involved years, not months. In both, the veteran died before resolution and claims were only continued by their widows. A case by case review of DVB and BVA decisions in POW claims of service-connected liver conditions will confirm this testimony.

Even in those cases where there is some evidence of alcohol abuse, that problem is symptomatic of the unresolved psychological trauma resulting from the POW experience. Also, as Robert Keehn, author of the NAS mortality study cited earlier, stated: "it seems likely that a poor diet during captivity might predispose the liver to alcohol damage." There is no record showing POWs were warned of such a danger any time after repatriation.

Conclusion

The inclusion of chronic liver disease as a presumptive condition is fully warranted by scientific and statistical data, supported by expert opinion, and is an effective solution to VA's current inadequate, protracted, costly and unfair adjudication policies.

B. ORGANIC RESIDUALS OF HYPOTHERMIA

Frostbite was a fact of life for thousands of Americans captured during the savage fighting that took place in the extremely cold winter of 1944–45, primarily during the Battle of the Bulge. It was also true for those captured earlier, particularly servicemen of lower rank. Clothing essential to protect themselves, including shoes, was often taken from them by their captors. They suffered repeated and severe exposure in railroad box cars, long marches, inadequate housing, and/or on work details in fields, mines and the like. Many prisoners in Asiatic camps in Japan and North Korea experienced similar exposure.

The acute symptoms of cold injury were tolerated along with the many other medical problems that characterized the POW experience as a result of the cold, malnutrition and brutality. Release from confinement typically occurred during combat. No examination or treatment was possible for the vast majority at this point or even in the crowded repatriation camps, as "Lucky Strike". As a result, for most it was not made a part of their service or discharge records. While many were granted service connection "by history" in the immediate post-war period, others who had suffered similarly were not.

While there is general acceptance by the military and VA concerning the exposure and hardships experienced—and the occurrence of frozen and frostbitten extremities, and while veterans can cite personal histories, supported by buddy statements, family members and employers, they face a long, protracted adjudication procedure. Despite this, they are typically denied service connection on two counts. First, the absence of an "evidence of record" in service records. Second, where medical examinations were given, they were limited to observable symptoms (i.e., skin changes, etc.) often not present in residuals of hypothermia.

One case (C 7 611 296) is representative of the time, frustrations and the problems confronting the POW. Unfortunately, like many POWs, he waited until 1973 to file a claim, when the residual symptoms were becoming progressively worse. He had statements from his place of employment from 1945 to the present, first-hand buddy statements describing his frostbite, family member statements, and the like. His service file was not available, presumably destroyed in the record center fire of some years ago. Despite all of the documented information the veteran provided, his claim was denied not only by DVB but by BVA in 1975, 1977, 1978 and 1980. In fact in 1980, the Chairman, BVA, took the extraordinary step of writing the veteran two letters. He stated "BVA and VA are obligated to consider claims . . . with a great deal of care . . . laws are interpreted quite liberally . . . however, the evidence (of record) must support the claim . . . the objective medical evidence indicates some claims (i.e., frostbite) were not medically recorded until more than a quarter of a century after your separation from service . . . you have submitted a considerable number of lay statements . . . however, in all candor, it would appear the question of your entitlement for frostbite of hands, ears and feet . . . are settled . . . the post-service medical evidence fully supports the conclusion that your disabilities did not begin in active service."

In late 1983, after at last employing an outside medical expert, BVA concluded that "new evidence" provided a basis of service connection. It should be noted the veteran had been concurrently treated by VA physicians for many years for "severe frostbite." After a very careful and thorough review, the expert stated in unmistakable terms: "it is evident from the record Mr. ——— had severe frostbite with damage to subcutaneous tissues . . . it is important to note there was exposure to cold over a longer period of time than the episode of freezing . . . Mr. ——— had cold injury of the hands and feet . . . that was certainly severe . . . he continues to exhibit all of the common symptoms . . ."

Only at this point did BVA conclude the condition was indeed service connected. Despite all the medical evidence and lay information he was then found to be 0% service connected! After strong protest, this was raised to a token 10% in 1985 and a further increase is under consideration as a result of Congressional concern about the fairness of treatment accorded this veteran. No final decision has been reached.

More than 10 years, thousands of dollars cost to VA, and great frustration to a deserving veteran have transpired in this case. It is repeated many times over with other POWs. It should be understood the substantive issues are the same. DVB statistical data from October 1, 1981 to December 1, 1984 does not provide a specific breakdown for residuals of cold injury. However, BVA data for 1983 shows that only 2 of 17 appeals were allowed.

Conclusion

The occurrence of cold injury is beyond question in thousands of POWs. Yet they must "prove" the service-relatedness in each case in protracted hearings and proceedings despite inadequate or nonexistent individual service medical records. Since ratings, if granted, rarely exceed 10%, it is both fair and cost effective to categorize organic residuals of hypothermia as a presumptive condition.

C. GASTROINTESTINAL DISORDERS

The grossly inadequate diet, persistent stress, spoiled or rotten food, and general unsanitary conditions combined to produce severe gastrointestinal upset in every POW. During captivity, chronic and severe diarrhea and continuing gastritis were inescapable. POWs were repeatedly warned in such repatriation centers as "Lucky Strike" that their stomachs were damaged and considerable care as essential to promote a return to normal. While many POWs did achieve effective recovery, many others did not.

A sizeable minority of the POW population have experienced a continuation of their symptoms after return. However, unless repatriation or separation examinations identified a specific disease process (as an active ulcer), these POWs were invariably described as "normal". The presence of continuing general gastric symptoms was recognized by examining physicians but not found suitable for diagnostic labeling. In many instances, the POWs' gastrointestinal problems gradually worsened ultimately resulting in a peptic or duodenal ulcer, chronic colitis, or some other specific GI condition.

Even though the POW had continuity of gastrointestinal symptoms that were treated for many years by self-medication or private physicians, adjudication panels and BVA Boards have typically denied service connection when such a condition is diagnosed at a later time. DVB statistical data on POWs from October 1, 1981 to December 1, 1984 reflects the high number of claims and a high denial rate. BVA data for 1983 is comparable revealing only one of 55 appeals was allowed.

The reasons for denial include the following:

"it would be conjectural to hold that ulcer disease was present during service even though we don't doubt that he had gastrointestinal problems in service and during the early postservice period. Many, if not most, such disturbances—even of a continuing nature—do not represent ulcer disease." (C 10 392 704)

"Service medical records do not show a diagnosis of an ulcer condition."

"Sound medical júdgment indicates there is no relationship between psychiatric conditions and an organic ulcer."

"Service medical records are negative for an organic stomach condition."

In practice, service connection requires a firm original diagnosis of an organic disease in the service medical records. Continuity of gastric symptoms are summarily discounted if acknowledged at all. The gradual process preceding the emergence of an ulcer is categorized as distinct from ongoing, oft-reported symptoms of gastric distress even though pre-ulcer symptoms are indistinguishable from those typically reported by POWs.

The continued insistence by rating panels and BVA Boards that current medical knowledge does not support a relationship between stress and later organic pathology is in contradiction to general medical care as practiced in VA and elsewhere. For example, Dr. Harold Morris, Senior Medical Clinical Coordinator for Ex-POWs for District ;ns26, stated the following at the VA's National Former POW Education Conference in March 1985 on the basis of 380 carefully evaluated POW medical protocol examinations.

". . . our evaluations indicate the profound degree of anxiety and depression presents . . . peptic ulcer disease with all of its manifestations and complications."

The supportive opinions of private physicians and VA treating physicians concerning the etiological relationship between the POWs continuing stomach problem and the eventual occurrence of an ulcer is almost invariably rejected.

Conclusion

POWs are routinely denied service connection for gastrointestinal disorders on the unfounded basis of no etiological relationship between gastrointestinal symptoms beginning as a POW and continuing down to the present unless the diagnosis of an organic condition had been made during service or within a two year period after discharge. Instead, a separate seemingly parallel process is inferred. Nor is continuing emotional stress, even when diagnosed, accepted as a factor causing or contributing to the later organic pathology. The high incidence of organic conditions in POWs with such histories has been documented by extensive POW evaluation programs in such VA Medical Centers as Loma Linda, California.

Establishing gastrointestinal disorders as a presumptive condition is fully warranted by the total picture, supported by treating physicians, in and out of VA, and urgently needed by POWs.

D. ARTHRITIS

Skeletal disorders, including arthritis, represent a major area of disability for POWs. It is also the area with the greatest number of denials according to the DVB statistics for October 1, 1981 to December 1, 1984. BVA data for 1983 shows that only 2 out of 45 appeals for service connection of arthritic conditions were allowed.

POWs are known to have experienced extensive physical trauma at the time of capture and throughout confinement. Airmen escaping from destroyed aircraft were subjected to not only the normal whiplash injury resulting from the opening of parachutes but to also numerous injuries to backs and extremities as a result of landing at night often after a low-level bailout on frozen ground in a semi-conscious state. Under these circumstances, they were totally unable to protect themselves from injury. After reaching ground they were subjected to further trauma from captors who typically struck them with rifle butts or other large objects.

Similarly, ground forces were subjected to extensive trauma due to exploding shells, mortars and bombs rendering them unconscious or unable to protect themselves. After capture, they, too, were subjected to much physical injury to their bodies by their captors. Savage beatings and injuries also characterized the POW experience.

Injuries not only occurred at a very high rate but were typically untreated or, where treated, were given very limited and crude care. Despite the array of traumatic injuries suffered, POWs were forced to march long distances, subjected to hard labor, exposed to the cold and the damp, and kept in cramped boxcars, cells or other circumstances damaging to their bodies.

In addition, the extensive and severe malnutrition has been shown by authoritative medical studies to result in osseous, cartilagenous and collagen degeneration.

The extensive and detailed clinical studies done on 380 POWs from the Protocol Medical examination at VAMC Loma Linda have confirmed a high incidence of degenerative joint disease and of osteoporosis occurring at a relatively young age. These findings are duplicated by similar examinations done at other VA facilities.

While the evidence for trauma resulting in lasting and/or progressive arthritic disorders is overwhelming, claims of POWs are typically denied on the basis that the service medical records (known to be inadequate, if existing at all) do not show evidence of the condition claimed. If the injury is accepted as fact, denial still occurs on the basis that there is no evidence to show that the injury resulted in permanent damage.

The fact that the circumstances under which the veteran was captured (i.e., bail-out and landing on frozen ground) would support the veteran's claim, buddy statements concerning the injury, are considered inadequate in the absence of medical records of injury and treatment in service. Even though arthritis is known to occur as a consequence of prior trauma that can gradually develop and worsen, tying this to even severe trauma as a POW is considered too "conjectural" to be given consideration. A case by case review of VA claims and appeals action will confirm this statement. Later claims based on earlier injuries are summarily denied.

Conclusion

Almost all claims for service connection for arthritis, traumatic or degenerative, are currently denied by DVB or BVA. The circumstances of capture, the general knowledge about damage that can occur or result from those circumstances, the damage done to musculo-skeletal due to malnutrition, first-hand accounts of injury supported by buddy statements—none of these factors balance VA decisions based on "medical evidence in the record" or the incorrect assumption that requests for service connection some years after return to service reflect evidence of no permanent injury. With high incidence of such injuries and the inadequacy of current VA procedures to reach any favorable decisions under circumstances described, the only viable option for these deserving veterans is inclusion of arthritis in the presumptive conditions.

E. CARDIOVASCULAR CONDITION

Extensive research from 1945 to the present has identified major risk factors contributing to arteriosclerotic heart disease. Diet, stress, exposure, injury, disease, dehumanization, and other destructive forces known to characterize the POW experience are all recognized as contributing adversely to the maintenance of health or to life itself. These factors, acting in combination and in the absence of supporting factors present in non-POW situations, are known to have permanent consequence. Are there any serious doubts that the starved bodies of African adults and children will result in shortened life and impaired health? Common sense as well as general medical knowledge tells us beyond a reasonable doubt that such damage will be present.

The severe nutritional deficiencies experienced by POWs, including beriberi, in the context of the other adverse factors, constituted a major destructive force on the bodies of survivors. In this respect Gilbert Beebe, author of the 1975 report of the NAS followup studies of morbidity in POWs, suggested that survivors may even have been of better-than-average physical constitution and emotional stability. Despite this likelihood, disease rates and periods of hospitalization are greater.

The examination and evaluation of 380 POW medical protocols by VAMC Loma Linda is representative of similar efforts in other VA health care facilities. Dr. Harold Morris, Senior Medical Clinical Coordinator for Ex-POWs for DM&S District #26, provided very substantial documentation for enduring damage to POWs, particularly in cardiovascular functioning. In addressing the DM&S National Former POW Education Conference, held in Dallas, March 5-6, 1985, he said the following:

"I have been impressed with the fact of the high priority (frequency) of specific disease entities of life-threatening nature in former POWs . . . the chronologic age . . . is an average of 63-65 years of age . . . (but) the degree of degenerative diseases, supplemented by *lack* of family history supporting an evidence of premature aging, puts the *physiologic* age at an average of 71-73 years."

He went on to further state:

"In our groups, both Japanese captives and European captives, there is a *profound* evidence, as high as 80% . . . of arteriosclerotic heart disease, predominately occlusive disease . . . however, this is not limited to ischemic heart disease but rather we have found a very high incidence of carotid occlusive disease . . . in addition to peripheral vascular occlusive disease, with claudication . . . time is running out for the WWII POWs and although it's not surprising . . . this places the . . . physicians' concern primarily upon prompt and definitive assessment and treatment."

Conclusion

Although these intensive studies confirm the judgment of numerous other experts in POW health consequences and the trend found in NAS longitudinal studies, claims for service connection are routinely denied by DVB on the basis of lack of medical evidence in the record, passage of time between POW experience and incidence of heart disease, and absence of a demonstrated etiological process in the individual case. Appeals to BVA rarely change this outcome. BVA statistics for 1983 show only 3 of 69 appeals were approved.

Inclusion of cardiovascular condition in the presumptive list is justified on the basis of the factors and facts presented in this testimony.

F. PERIPHERAL NEUROPATHY

This condition was known to be prevalent during captivity as a result of nutritional deficiencies and/or damage to tissue and nerve-endings due to cold injury. Permanent and/or progressive damage is not unexpected.

DVB adjudication action and BVA appeals have not been favorable and have imposed impossible requirements upon POWs in terms of evidence in the record and precise etiological processes. Neither provide statistical data specific to this area but include it in broader categories. Detailed discussion contained in previous sections apply and need not be repeated here. Case-by-case review of DVB and BVA actions will confirm the very high denial rate.

Conclusion

POWS are confronted with a high incidence rate for this problem but existing VA rules and regulations preclude the approval of these claims. The inclusion of peripheral neuropathy in the presumptive list is warranted and supported by all medical experts knowledgeable in POW health problems.

G. IMMUNOLOGICAL DYSFUNCTIONS

There is increasing current evidence of immunological deficiencies resulting from stress. Similarly, there is growing evidence that severe nutritional deprivation can play a significant role in depleting or damaging the capacity of the human body to resist destructive disease processes. These include infectious disorders, allergies, auto-immune disease, and neoplastic diseases. The POW experience, by a potent combination of stress and nutritional factors, is believed by many knowledgeable experts to cause such damage to immunological capacities.

The VA Study of Former POWs published in 1980 acknowledges that POWs have a higher incidence and greater variety of diseases attributable to the POW experience. Dr. Harold Morris noted from the 380 POW medical examinations completed at VAMC Loma Linda that the incidence of primary neoplasm in the overall group of POWs is "alarming". His medical colleagues believe that malnutrition and loss of immunocompetence is a major factor, particularly with respect to pulmonary disease. The possibility that premature aging is a reflection of impaired immunological functioning is also suggested.

Conclusion

The evidence supporting immunological deficiencies in POWs comes from many different sources but is persuasive. VA adjudication rules and regulations do not offer any means for addressing this problem. Its manifestation is most evident in POWs confronted by a variety of life-threatening but seemingly unrelated disease processes, usually occurring at an earlier age than normally associated with "declining health". The inclusion of immunological dysfunctions in the presumptive list is the only viable option for POWs with an accelerated pattern of declining health and occurrence of the types of disease processes identified.

H. CHRONIC PULMONARY DISEASE

During imprisonment lung infections, including tuberculosis and pneumonia, were prevalent. The malnutrition, exposure, physical and mental exhaustion—coupled with forced labor, long marches, confinement in holds of ships or boxcars—produced loss of resistance to disease processes. This is verified by NAS mortality and morbidity studies. The greater vulnerability to repeated pulmonary and pleuritis infections is most recently documented in the 380 POW medical protocol examinations at VAMC Loma Linda.

POW claims in this area, except for TB, are routinely denied on the basis that pulmonary problems experienced while a POW were transitory; therefor, unrelated to current chronic pulmonary problems. Yet POWs frequently show a pattern of repeated lung problems resulting in chronic pulmonary disease. Loss of resistance (loss of immunocompetence) is an underlying factor. Case-by-case review of POW claims will substantiate this as do DVB statistics from October 1, 1981 to December 1, 1984.

Chronic pulmonary disease is a significant problem, one that is not effectively addressed by current adjudication policies and regulations. In view of the documented vulnerability of many POWs to chronic lung disease, including this as a presumptive condition is fully warranted.

SUMMARY

Mr. Chairman, in conclusion, we believe the total record of post-service adjustment of POWs overwhelmingly confirms the conclusion that this imprisonment resulted in diverse and severe later health damage. This was predicted by Congress and VA, repeatedly verified by research here and abroad, and is unequivocally acknowledged by physicians with expertise in this area everywhere.

The latest of these studies we have repeatedly cited in our testimony. It is the evaluation of 380 POW medical examinations conducted at VAMC Loma Linda. However, it does not stand alone. Charleston VAMC and many other fine VA facilities are conducting the same examinations—and reaching similar conclusions. We are particularly impressed, and reassured, by the fact that physicians in VA facilities who become directly involved in POW health matters have few reservations about the permanence and variety of health problems resulting from the POW experience. We are also grateful for the fact that these fine professionals grow to perceive POWs as very worthy and deserving veterans who served their country heroically.

Mr. Chairman, we understand and support the desire of the VA to identify the precise etiological pattern between the POW experience and specific disease entities. Nevertheless, we do not believe this worthy scientific objective can continue to justify further delays, particularly in view of the age of these veterans and their long postponed benefits.

We believe, as does the POW Advisory Committee (after three years of intensive study) and a growing body of VA physicians throughout this country, that a significant medical consensus now exists in support of the conditions proposed for inclusion on the presumptive list.

We reluctantly call to your attention that, in the 3½ years since the passage of PL 97-37, DVB has yet to make a single definitive change in regulations governing the adjudication. It is true that adjudication staff has been urged to give POWs the "benefit of the doubt" yet it has not instructed them *how* to do so. Reasonable doubt remains firmly tied to available medical "evidence" when such evidence is grossly inadequate or non-existent for POWs. The decisions, and reasons for those decisions, remain precisely as before PL 97-37 was enacted.

Finally, Mr. Chairman, we are keenly aware of budget constraints. We believe that the cost of this legislation will be far less than VA estimates. We call to your attention that VA estimates for PL 97-37 were four times greater than actual costs. We further call to your attention the fact that there are important offsetting costs. POW claims, appeals, and reviews take far longer time than the single-event approach utilized by VA. The time before there is resolution of a claim is many years and many thousands of dollars in administrative and professional time. This is far from cost effective since 71% of favorable adjudication action on some 14,000 adjudication action on POW claims during the period October 1, 1981-December 1, 1984 were at the 0% or 10% level and only 19% were at the 30% level.

But, more important, Mr. Chairman, we believe the American public recognizes the incredible sacrifices POWs made for their country—and will wholeheartedly approve of this legislation.

Thank you.

TESTIMONY OF EDWARD JACKFERT, PAST NATIONAL COMMANDER OF THE AMERICAN DEFENDERS OF BATAAN AND CORREGIDOR, INC.

Mr. Chairman, and fellow members of the House Committee on Veteran's Affairs, the American Defenders of Bataan & Corregidor appreciate this opportunity to testify on behalf of H.R. 864, a bill which would amend Title 38, United States Code, to improve veteran's benefits for former prisoners of war.

This year is the 40th anniversary of the cessation of hostilities with Japan, and the return to freedom of those survivors who so gallantly defended America's interests in the Philippines during the outbreak of World War II.

The tremendous defense put up by a small group of American and Filipinos against a superior force of Japanese troops attracted world-wide attention.

Increasingly, historians reviewing those fateful days realize that the defense of the Philippines against the overwhelming power of the Imperial Japanese armed forces, bought for our country added time for which to mobilize our strength to return for final victory. Without that time, the outcome of the war in the Pacific might have been disastrously different, and the course of modern events would have taken a turn from which we could still be suffering.

As close as we can determine, there were approximately 20,000 Americans who surrendered to the Japanese forces by early May 1942. Approximately 2330 died on the infamous "Death March". Rough estimates of those who survived the almost 3 years and four months as Japanese prisoners of war total 11,000. The number of survivors that our organization can account for today is around 6000. We have lost approximately 70% of the original count of Americans in the Philippines at the onset of World War II. These statistics further disclose, that we have the highest mortality rate of all veteran's organizations in the United States.

After repatriation from the various prison camps, some were given cursory physical examinations, while others were processed without any examination.

Thereafter, the survivors of these prison camps attempted to enter the mainstream of American life. Many stayed in the Armed Forces, hoping that their health problems would be adequately cared for. Others settled down and once again became the ordinary working citizen.

Those who returned to civilian status and had health problems, attempted to get help from the VA and identification of their disabilities as service-connected. On most occasions they were rejected. They became frustrated and refused to go back. Even to this day, we find that many do not have much faith in the VA system.

Mr. Chairman, finally after 33 years, the complaints of the POW community finally reached some ears. The House and Senate Veterans Affairs committees became concerned over the health and welfare of the former POWs and directed the VA under Public Law 95-479 (enacted October 18, 1978), to complete a comprehensive study of the health-care and compensation needs of veterans who were former prisoners of war.

The study was completed in May 1980. It contained many recommendations, some to be enacted by regulation and other by proposed legislation.

As a result of this POW Study, Congress enacted Public law 97-37 on August 1, 1981. This law granted former POWs presumption of service connection for various malnutrition disorders and anxiety neurosis. The law also specified that an Advisory Committee on Former Prisoners of War be formed, which was to include recognized experts in fields pertinent to disabilities prevalent among former POWs, and representatives of disabled veterans. This committee was formed on January 26, 1982.

After three years of thorough professional study of the health care and other problems of the former prisoner of war with the Veterans Administration, the committee has made many recommendations for changes within the Veterans Administration system relating to former prisoners of war. The committee also recommended the following additional presumptions of service-connection for the diseases and disabilities listed below:

(1) Chronic liver disease,
(2) Organic residuals of hypothermia;
(3) Gastro-intestinal disorders;
(4) Cardiovascular conditions;
(5) Arthritis;
(6) Peripheral neuropathy;
(7) Immunological dysfunctions;
(8) Chronic pulmonary disease.

The American Defenders of Bataan and Corregidor, Inc. whole-heartedly support the committee's conclusion that the additional presumptions of service-connection for the above-mentioned diseases and disabilities be made part of Title 38 of the U.S. Codde. We believe there is sufficient medical and statistical evidence to support this conclusion.

We are sure that Congress is well aware that all prisoners of war of the Japanese government suffered from a diet that was extremely deficient in quantity and quality, so that severe body weight loss and multiple nutritional deficiencies of extreme degree developed. Sanitation facilities were primitive and there were no medicines available. These prisoners of war were subjected to hard labor and often brutal treatment.

Since the return of the prisoners of war in the year 1945, there have been many studies made of their physical and mental conditions. The War Claims Commission provided one of the earliest surveys in 1950. It cited the opinion of several non-POW medical experts on the residuals of World War II experience. These physicians were asked the questions: "Do you believe that the average American physician, because of the comparative variety of malnutrition here, would have difficulty in recognizing residuals of malnutrition for what they are?" The unanimous reply from the physicians was "Yes". Another question asked was "Do you believe that because of the paucity of available knowledge on the long term effects of malnutrition, and because of difficulty of diagnosis, that former POWs shoud receive the benefit of presumption of service connection disability with the attendant privilege of entering a veteran's hospital?" The physician respondents all answered "Yes."

A Pacific Theater POW physician stated that "It is my opinion that virtually none of the released POWs of the Japanese who underwent internment for three to three and one-half years escaped without some residual impairment of their health". Yet another Pacific POW physician declared that "It is my opinion that no one who suffered the prolonged starvation, degradation, and physical suffering experienced by this group has been able to make full recovery, either physical or emotional. It is also my opinion that one who has not experienced such a condition has no concept of the problem presented by these men".

Dean Nefzger in his study of 1970, suggested that a significantly higher percentage of deaths due to cirrhosis might have its origin either in malnutrition during imprisonment or a "different standard or manner" of living since repatriation.

Gilbert Beebe, in his study of 1975, found that through 1965, former Pacific Theater POWs sustained a higher morbidity rate from tuberculosis and other infective and parasitic diseases, as well as nerve inflammation (neuritis), peripheral neuropathy, and gastrointestinal, genitourinary, and orthopedic problems. Beebe found that arteriosclerotic heart disease was quite prevalent among former Pacific Theater POWs.

The most recent National Academy of Science/Naval Research Center Study found that former Pacific Theater POWs were suffering from a significantly greater amount of service connected disabilities due to the following conditions: musculoskeletal problems, (arthritis and back disorders), systemic diseases (avitaminosis, beriberi, pellagra, malaria), eye diseases (conjunctivitis), respiratory problems (residuals of frozen feet), gastrointestinal diseases, (peptic ulcer, gastritis, amebiasis, dysentery, hemorrhoids, hepatitis), genitourinary problems (prostate gland infection), skin diseases (scars, dermatophytosis), neurological disorders (peripheral neuropathy), and psychiatric problems (anxiety neurosis).

Also, there have been studies world wide of the residual effects of malnutrition on the survivors of prison camps. In 1961, there was an International Conference on the Later Effects of Imprisonment and Deportation held at the Hague. There were 70 participants from 12 countries, including 40 medical and legal experts. The conference reached several conclusions, summarized as follows:

(1) The conference was of the opinion that there exist ailments and disabilities which appear long afterwards among those who were interned or imprisoned in prison camps.

(2) These effects can become manifest at any time after liberation, and no time limit can be set for their appearance.

In a 20 year follow up study of Norwegian political prisoners deported to Germany during World War II, Entinger and Strom found a significantly higher morbidity and mortality in the prisoner group as compared to the Norwegian general population. In particular, significantly higher morbidity rates for the prisoners were found for diseases of the nerves, lungs, digestive tract, muscles and bones. They contend that to this day, the former prisoners are vulnerable to all kinds of stress which can upset their equilibrium and result in a manifest illness.

Fisher found spinal degeneration in post-mortem examinations of 11 Canadian POWs performed 4 to 7 years after liberation, and reported an excessive amount of gastrointestinal, neurological, and cardiovascular problems in his sample of POWs.

Coke studied 391 former POWs for 12 years after repatriation. Each former prisoner was given a physical examination at least annually. Coronary artery disease was the most common cause of death, particularly in the younger age groups. The incidence of cirrhosis of the liver was also found to be excessive.

The studies and publications on former POW physical and mental problems show that they manifested a significantly higher amount of a particular type of disease upon repatriation which were related to the malnutrition, torture, climatic exposure, and other deprivations of internment. Epidemiological follow up studies of former POWs indicate that the residuals of these and other disabilities have persisted until the present time, accounting for significantly higher post-repatriation mortality rates among former POWs relative to other veterans and control groups.

Most of the information disclosed above relating to POW disabilities and diseases came from the VA's own publication "Study of Former Prisoners of War", published in May 1980.

Of more recent nature, I would like to quote from the "Physician's Guide for Disability Evaluation Examinations" published by the Department of Medicine and Surgery of the Veterans Administration, under the date of March 1, 1985. A part of Chapter 17, Medical Evaluation of Former POWs reads as follows: "Studies in this country and abroad have shown that the physical deprivation and psychological stress endured as a captive have lifelong effects on subsequent health, social, and vocational adjustment. Specific residuals are known to be induced by prior malnutrition. Former POWs have significantly higher incidence rates for illnesses in many body systems, and longer hospital stays. Vulnerability to psychological stress is also markedly increased.

Also of more recent nature, we find that thousands of Ethiopians are currently suffering from malnutrition due to food shortages. Medical experts and scientists throughout the world are predicting that the residual effects of malnutrition suffered by the Ethiopians will have a profound disabling effect upon the physical and mental conditions of these individuals.

The statements of these medical experts and scientists relative to the Ethiopian situation, supports the previous studies made relative to the effects of malnutrition on prisoners of war during World War II.

The American Defenders of Bataan & Corregidor have never claimed that we were special veterans and should be rewarded for what we went through in World War II, what we are saying is, that we do have special problems that have developed over the years resulting from our prisoner of war experience. We want these problems recognized by the Veterans Administration.

Mr. Chairman, our problems with the Veterans Administration are such that we need legislative action. Time is of the essence. Our average age is well over sixty, and we believe that the cost will not be that great to the government.

We implore you to take affirmative action on this bill and assist those former prisoners of war who so gallantly defended their country in World War II.

Thank you again for giving us the opportunity to express our views on this most important piece of legislation.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

CHAIRMAN APPLEGATE TO VETERAN'S ADMINISTRATION

Question 1. How many former prisoners of war, captured in the European Theater of Operations during World War II, were returned to military control? Of the number returned to military control, how many are estimated to be living today?

Answer. We do not maintain our own figures on these subjects. The best available estimate is that 93,941 Army and Air Corps personnel were captured and imprisoned in the European Theater. Of these, 92,820 were returned to military control. As of January 1, 1985, 66,532 were estimated to be alive. Navy and Marine Corps figures are not available for specific theaters of operations. The total Navy and Marine Corps figures for World War II are estimated at 6,122 captured, 4,703 repatriated, and 2,949 alive as of January 1, 1985.

Question 2. How many former prisoners of war, captured in the Pacific Theater of Operations during World War II, were returned to military control? Of the number returned to military control, how many are estimated to be living today?

Answer. The best estimate for the Pacific Theater is that 27,465 Army and Air Corps personnel were captured, 16,358 were repatriated, and 10,255 were alive as of January 1, 1985. For Navy and Marine Corps figures, refer to the response to question one.

HON. JOHN PAUL HAMMERSCHMIDT TO VETERAN'S ADMINISTRATION

Question 1. How do you answer the assertion that enough evidence in the epidemiological studies and medical literature exists now for finding service-connection for the conditions listed by H.R. 864?

Answer. Evidence does not exist for the class groups of disease listed in H.R. 864. We draw particular reference to such relatively non-descript entities such as arthritis and immunological dysfunctions. While there is epidemiological evidence for certain diseases in these categories, the data is conflicting. An example is the rate of cardiovascular disease among former POWs where some studies show no significant difference between former prisoners and non-POWs.

Question 2. After the National Academy of Sciences completes its morbidity study on Prisoners of War from World War II and the Korean Conflict, does the VA plan to take another look at the list of presumptive disease?

Answer. Assuming completion of the planned (5th) NAS/NRC longitudinal study the VA will certainly look at the list of presumptive diseases.

Question 3. Please tell the Committee more about the National Academy of Sciences morbidity study on Prisoners of War from World War II and the Korean Conflict.

Answer. The current NAS/NRC study is one of a number of studies directed at identifying and measuring the long-lasting effects of captivity upon the health of repatriated former prisoners of war (POW). Four reports have been published, providing morbidity, mortality, and disability information. The studies have been set up as historical longitudinal cohort studies, with groups of POWs from World War II (European and Pacific theaters) and the Korean conflict, and selected non-POW controls. Mortality was first studied approximately six years after repatriation, then 20 years (12 years for Korean conflict veterans), and finally 30 years. Morbidity and disability were first studied at approximately six years after repatriation, and then 20 years. The present NAS/NRC study of roughly 4,000 subjects will extend the morbidity and disability follow-up to nearly 40 years (32 for Korean conflict veterans).

The present NAS-NRC study consists of several parts. A questionnaire has been mailed to the POW and appropriate control subjects. The questionnaire was developed with advice from the VA Administrator's Advisory Committee on Former Prisoners of War, Medical Subcommittee, and focuses on their concern about mental problems, especially depression. The questionnaire will also collect data on the subject's admission to hospitals, and VA records will provide data on VA hospitalization and disability compensation. The analysis is expected to provide a comprehensive picture of the morbidity and disability of WW II and Korean conflict POWs as compared to their non-POW controls.

Question 4. What major research on POW related diseases is the VA involved in or following, other than the National Academy of Sciences morbidity study?

Answer. In response to your question we have attached data concerning four VA research projects that involve former prisoners of war.

[The data referred to follows:]

HAMMERSCHMIDT

Chronic Strongyloidiasis in Far East Ex-Prisoners of War from World War II

PELLETIER, LAWRENCE L., M.D. 452 Wichita, KS

Project 1
Last Report, PROGRESS 10/84

STRONGYLOIDIASIS, EX-PRISONERS OF WAR

This study of 500 survivors of the USS Houston and 131st Artillery Battallion captured by the Japanese during World War II continues to demonstrate persistent symptomatic infections with Stronglyoides stercoralis. To date, 274 individuals have submitted questionnaires and stool specimens for examination. Sixty-four individuals had Strongyloides larvae detected in stool specimens. Forty-three have been treated with thiabendazole with no documented therapeutic failure in individuals who completed 4 days of treatment. Fourteen individuals have been treated with mebendazole with documented treatment failures. Eosinophil counts, total IgE levels, and the NIH ELISA for Strongyloidiasis have been obtained on 196 individuals, some after treatment and as a screening tests in others.

In ongoing studies the value of eosinophil counts, IgE levels, and the NIH ELISA for strongloidiasis are being evaluated as screening tests and in the assessment of adequacy of treatment. The effectiveness of mebendazole therapy is also being evaluated. A major problem encountered in these studies are the nonspecific symptoms of patients and the lack of clear end points of cure due to the difficulty of demonstrating the parasite in stool specimens.

Holtzman Inkblot Differences Among PTSD/Non-PTSD POW Veterans
QUERY, WILLIAM T., Ph.D 437 Fargo, ND
PROJECT 6
LAST REPORT, PROGRESS 12/84
ASSOCIATES: MEGRAN, J

Post-traumatic stress disorder, projective technique, prisoner of war

PROJECTED OJECTIVES: There are a few studies concerning what constitutes test expectancies among PTSD Vietnam or other war veterans, and none using projective techniques. The Holtzman Inkblot Test (HIT) holds promise of being such a test because of its breadth of scores and reliability.

PLAN: Subjects will be POWs called back for evaluation of PTSD.

METHOD: Subjects will be divided between those who have been agreed on by a panel to exhibit PTSD, and those who have no symptoms of PTSD.

CLINICAL RELATIONSHIP: Based on the description of PTSD in the DSM III page 238, the following test hypotheses will be studied:

a) reexperiencing of the trauma as evidenced by intrusive recollections of the event in ambiguous stimuli. POWs with PTSD will exceed POWs without PTSD. There will be a greater frequency of war images and increases in Hs (hostility) among the HIT responses;

b) numbing of responsiveness to or reduced involvement with the external world. There will be significant fewer H (human) responses, especially HM (human movement); c) hyperalertness or exaggerated startle response. There will be greater frequency of anxiety responses and AA (affect arousal), and avoidance of activities that arouse recollection of the traumatic event. There will be a greater number of (R) rejections of the cards.* These indices will be less frequent among WWII and Korean-age veterans than among Vietnam veterans.

PROGRESS TO DATE: To date the call back of POWs who have availed themselves of this program has not had a sufficient population of Vietnam veterans (upon whom the PTSD criteria were derived in the first place) against those Vietnam POWs not meeting the criteria.

*There will be greater rejections on specific cards which have certain stimulus properties (Hill E: The Holtzman Inkblot Technique, 1972, Jossey-Bass, pp. 115-120).

Card 3A: fear of destruction; Card 5A: anxiety and loneliness; Card 23A: death and destruction; Card 43A: depression caused by guilt.

Study of the ex-POW Health/Psychosocial Support System
REMER, STANLEY G.   589 KANSAS CTY, MO
PROJECT 1
LAST REPORT, INITIAL 12/84

ASSOCIATES: Armstrong, R

PRISONER, WAR, PSYCHOSOCIAL, SUPPORT

Objectives: The purpose of this project is to study the ex-POW and his health/psychosocial support system.

RESEARCH PLAN AND METHODS: A mailed questionnaire will be sent to each current member of the Airs Capital Chapter of ex-Prisoners of War. This questionnaire will develop identification data and health/social data on each ex-POW. The health/social data obtained will include areas such as the home environment, marriage/family relationships, health care, resources, health habits and health of spouse. The VA medical record of all ex-POW respondents who complete a questionnaire will be reviewed for diagnoses and care needs. A survey will be completed of available community and VA resources to meet the ex-POWs needs.

CLINCIAL CORRELATION OF AUTOMATED NEUROPSYCHOLOGICAL TEST SYSTEMS
GOLDSTEIN, GERALD, PH.D. 645 PITTSBURGH, (HD), PA
PROJECT 3
LAST REPORT, PROGRESS 3/85

ASSOCIATES: Shelly, C

Neuropsychology, Aging, Screening Batteries

Objectives: Refinement of neuropsychological assessment procedures, automation of those procedures and neuropsychologically oriented rehabilitation of brain damaged patients.

FINDINGS TO DATE: Several studies have been completed regarding comparisons between the Halstead-Reitan (HRB) and Luria-Nebraska (LNNB) Neuropsychological Test Batteries, as well as between the LNNB and tests of the intelligence and achievement. Exceedingly high correlations were obtained in all cases, suggesting that the LNNB and HRB assess essentially the same domains of cognitive function. We also found that accuracy of clinical judgements regarding presence or absence of brain damage was equally high for LNNB and HRB. We also are now analyzing data regarding accuracy levels for predicting lesion lateralization. We have recently developed and reported on a short form of the LNNB oriented toward assessment of dementia.

In the alcoholism area, we recently reported the finding that adolescent sons of alcoholics demonstrated certain neuropsychological deficits not found in age and education matched sons of nonalcoholics. We also found that while withdrawal seizures were not indicative of extent of neuropsychological deficit in white alcoholics, they were in black alcoholics.

In the area of rehabilitation, we have reported on three methods of memory training for densely amnesic (Korsakoff) patients, all of which were reasonably effective. All three methods involverd extensive repetition of small item stes, without mnemonic aisd or related mediating devices. The findings were similar to those reported earlier in an evaluation of reality orientation therapy in which it was shown that amnesic patients sucessfully learned samll amounts of information through extensive repetition.

We are in the process of reviewing data obtained from a sample of 41 elderly ex-POWs all of whom were participants in the "Bataan Death March" or were prisoners of the Japanese during WWII. It was found that most of these individuals continue, some 40 years after the experience, to manifest significant symptoms of post-traumatic stress disorder, notably sleep disturbance.

Question 5. On page 8 of Dr. Theodore Woodward's written testimony, he argues for certain adjudication procedures for former POWs. Will you please comment on how the suggestions of Dr. Woodward differ from your current procedures. The pertinent comments of Dr. Woodward are enclosed for ready reference.

Answer. Dr. Woodward's first instance is a veteran who never fully regained health following imprisonment and exhibited abnormalities on a continuing basis during the ensuing years. In such a case, current procedures require establishment of service connection.

The second instance is of a veteran who first manifested symptoms many years following service. Under these circumstances, the only means for establishing service connection is through consideration of the factors in each case. Currently, we do consider medical history and physical findings. It is unclear how social and emotional findings would apply except in psychiatric cases. Our position on demographic and epidemiological findings is that studies to date have produced no consensus that would allow us to consider such findings for conditions other than those already subject to presumptive service connection.

Question 6. During testimony on H.R. 864, statements were made concerning a lack of sensitivity of some VA employees on POW claims for compensation. Please tell the Committee what VA has done in this area, including new program guides, publications, training, etc.

Answer. Veterans Administration efforts to implement Public Law 97-37 began on August 14, 1981, the date of enactment. Since that time a variety of regulations, circulars, program guides, informational pamphlets and policy letters have been published as instructions and guidance to regional office and medical center personnel on the handling of claims from and examinations of former prisoners of war. These publications were designed to implement both the letter and the spirit of the law.

The initial circular on POW claims processing, DVB Circular 21-81-9, was published on September 18, 1981, with a revised edition on December 6, 1983. The Agency also produced a videotape entitled "A Flag for POW" to educate and sensitize all VA personnel to the hardships endured by former POWs and the benefits available under the new law. Viewing of this videotape continues to be a requirement in field station orientation programs for new employees. Program Guide N-13 was revised on June 22, 1983, with guidance for rating boards. DM&S Circulars 10-83-56 and 10-84-44 provided guidance for examining physicians. In addition to these publications, DVB and DM&S have conducted training in the field to emphasize the special circumstances of the POW experience.

Question 7. Do you have statistics on the number of individuals who were POWs who later died and had their deaths held to be service connected? If so, please provide them to the Committee.

Answer. We do not have such statistics.

HON. DAN MICA TO VETERAN'S ADMINISTRATION

Question 1. If a man is held against his will during a period of war, what is the difference between him and a "prisoner of war"?

Answer. Belligerent troops are disarmed by neutral countries when the troops cross the neutral frontier. They are detained in honorable confinement until the end of the war. While thus detained, they are said to be interned, a condition which they must not resist, and the expense of which their government is in honor bound to bear. A prisoner of war is confined by a hostile country at its own expense in more rigorous confinement.

Question 2. How are the conditions of internment different from the conditions of detention or internment in hostile countries or of prisoners of war?

Answer. The examples of internment of which we are aware occurred during World War II. In many of these cases, the internee was not physically confined. In no case do we know of circumstances of internment which approximated in any way the hardships of POW status in Japan or Germany.

Question 3. Should PL 97-37 be re-evaluated because it completely ignores the plight of internees? Under the definitions of PL 97-37, personnel held hostage by Iran and those from the Pueblo are eligible for POW status. Isn't something needed to help those World War II military personnel who were interned?

Answer. We do not believe that special provisions are necessary for internees in neutral countries. First, we question any assumption without detailed study that internees as a class suffered unusual hardships. Second, the VA already recognizes the unique circumstances of the combat veteran. It is difficult, if not impossible, to record the onset of disability properly in a combat situation. It is for this reason that the VA accepts as sufficient proof of service-connection satisfactory lay or other evidence which indicates that a disability was incurred or aggravated during combat. This rule clearly applies to internees in neutral countries or, for that matter, to those who evaded capture.

Question 4. Don't we have a responsibility to those internees because they served their country and unlike peacetime POWs did in many cases because they had no choice but to be drafted?

Answer. We believe that the provisions for all combat veterans are sufficient to meet our responsibilities to internees.

Question 5. If Public Law 97-37 were to be amended by adding in part (A) of the definition, "or as a result of a hostile action", or inserting the words "or neutral" after "or a hostile force" permit internees to claim the same benefits as POWs?

Answer. The addition of "or as a result of a hostile action" to part A of the definition or the insertion of the words "or neutral" after the word "hostile" would permit internees to claim the same benefits as former POWs.

Question 6. Without amending any law, could the VA be directed to rewrite its regulations as to include those individuals interned during World War II for at least six (6) months as being entitled to certain medical benefits?

Answer. It is our understanding that the thrust of this question concerns the potential eligibility for VA health benefits under Public Law 97-37 as former POWs of World War II veterans who were interned during that way by a government which was not at war with the United States. Benefits under Public Law 97-37 are available only to former POWs as defined by section 3 of that law. As regards a veteran interned during a period of war, the term former prisoner of war "means a person who, while serving in the active, military, naval or air service, was forcibly detained or interned in line of duty—(A) by an enemy government or its agent, or a hostile force, during a period of war." 38 U.S.C. § 101(32). Thus a veteran who was detained during World War II by the government of a neutral country, is not a former prisoner of war, for purposes of eligibility for VA benefits. VA would have no basis in law to purport to promulgate regulations conferring such status.

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